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ABSTRACT

In the current therapeutic climate it is essential for mental health professionals to address biological and health issues along with social and psychological issues in their care delivery. The increasing economic and professional need for integrative treatment has necessitated the trend toward biopsychosocial approaches to maximize treatment outcomes. This book is geared towards psychotherapists and counselors who work with individuals and couples and is particularly helpful for working with difficult-to-treat cases where conventional treatment approaches have been ineffective. Chapter 1 describes four levels and dimensions of integrative application to therapy: theory and techniques; tailoring treatment to client or couple need; domains; and common factors. Chapter 2 describes an integrative approach that emphasizes the integration of theory and technique. In Chapter 3, two levels of integration are presented: the integration of theory and technique, and tailoring. Chapter 4 focuses on Biopyschosocial therapy. Chapter 5 reflects on issues and developments in the biopsychosocial and integrative approaches to the treatment of individuals and couples. (Contains 3 tables, 6 figures, and 79 references.) (JDM)

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THE FAMILY PSYCHOLOGY AND COUNSELING SERIES

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# Integrative and Biopsychosocial Therapy: Maximizing Treatment Outcomes With Individuals and Couples

*edited by*
Len Sperry

■■■■

*series editor*
Jon Carlson

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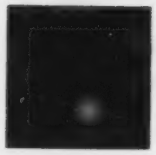
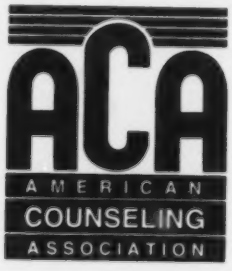


# INTEGRATIVE AND BIOPSYCHOSOCIAL THERAPY: MAXIMIZING TREATMENT OUTCOMES WITH INDIVIDUALS AND COUPLES

Edited by
Len Sperry

THE FAMILY PSYCHOLOGY AND COUNSELING SERIES



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the International Association of Marriage and Family Counselors

**INTEGRATIVE AND BIOPSYCHOSOCIAL THERAPY: MAXIMIZING TREATMENT OUTCOMES WITH INDIVIDUALS AND COUPLES**

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# From the Series Editor

Integrative approaches in family therapy and psychotherapy are rapidly becoming the treatment of choice for counselors and therapists. Biopsychosocial ideas have become necessary because of the changes in managed-care systems. Counselors and therapists are well prepared in the psychosocial dimensions but must also learn to address health and biological issues. This can no longer be deferred to medical personnel because so many health issues (both mental and physical) have behavioral components and vice versa. It is not surprising that over one half of all problems brought to medical personnel do not involve any virus, bacteria, or fungus but are actually a result of lifestyle choices.

The strengths and limitations of competing theoretical approaches have been discussed in most major textbooks on treatment. For example, psychodynamic approaches are useful for the identification and treatment of character problems; experiential techniques facilitate emotional awareness; cognitive approaches are helpful in modifying beliefs; and behavioral treatments facilitate the acquisition of new patterns of behavior. Difficult or complex families will benefit from treatment strategies that draw from diverse theoretical models.

> [E]ffective treatment is most likely to be rendered when the couples therapist has a solid grounding across diverse theoretical approaches, has acquired a rich repertoire of intervention techniques linked to theory, engages in comprehensive

> assessment of the marital and family system, and selectively draws on intervention strategies across the theoretical spectrum in a manner consistent with an explicit case formulation. (Snyder, 1999, p. 84)

This is much different from what was loosely called eclectic. The eclectic strategies involved doing what feels right, using trial and error, and working on the basis of intuition. The integrative movement uses a "technical eclecticism" or an "informed pluralistic" approach that is rooted in solid assessment and the selection of strategies and techniques that are supported by research.

Len Sperry and his collaborators have developed an important monograph that provides the needed information on these approaches to helping. It is my hope that counseling practitioners use this monograph to come "up to speed" with the rest of the mental health profession. The days of single approaches that only focus on the psychosocial dimensions of helping are over. Today's multiproblem families require complete approaches that are able to be adaptive to all aspects of the problem.

***—Jon Carlson, PsyD, EdD***
*Series Editor*

## Reference

Snyder, D. K. (1999). Pragmatic couple therapy: An informed pluralistic approach. In D. M. Lawson & F. F. Prevatt (Eds.), *Casebook in family therapy* (pp. 81–110). Pacific Grove, CA: Brooks/Cole.

# Preface

There is increasing interest in biopsychosocial and integrative therapeutic approaches these days. This interest has been peaked by theoretical developments, economic necessity, and professional need. Recent theoretical developments include postmodern approaches such as solution-focused and narrative therapy, the refinement of individual and couples interventions, and the recognition of readiness for change and other client factors in the change process. Economic factors include the demands of payers and consumers of therapeutic services for accountability in terms of cost-effectiveness and maximizing treatment outcomes. Professional factors are complex and variable. For example, in endeavoring to extend the scope of practice for psychologists, the American Psychological Association has recently designated professional psychology a primary health care specialty and adopted the biopsychosocial model as the basis for planning and implementing therapeutic interventions. A related development has been the movement of individual, couples, and family therapists into primary-care medical settings.

All three sets of factors have significantly influenced the trend toward biopsychosocial and integrative approaches. Although there have been efforts toward integration since the 1950s, these efforts have been isolated and largely limited to integration at the theoretical level. However, the recent press of professional and economic factors has thrust efforts toward integration at several levels into the mainstream of clinical practice today.

Currently, while there is a growing literature in integrative family therapy, there is a very limited literature addressing integrative therapy with couples. Although there is an overlap between couples therapy and family therapy, there are also sufficient differences in both formulating and implementing treatment between couples and families that a book targeting the integrative treatment of couples would fill a void in the literature.

*Integrative and Biopsychosocial Therapy: Maximizing Treatment Outcomes With Individuals and Couples* is aimed at individual psychotherapists as well as counselors and therapists who work with couples. It will be particularly useful to therapists working in settings that emphasize treatment outcomes or working with difficult-to-treat cases in which conventional treatment approaches have been ineffective. We expect that it will be used in graduate programs in counseling and clinical psychology as well as in marital and family therapy.

The book consists of five chapters. Chapter 1 overviews the evolution of integrative therapy over the past 30 years in terms of four increasingly complex dimensions of integration: theory and technique, tailoring, domains, and common factors. Three different approaches to biopsychosocial and integrative therapy are then explored in chapters 2, 3, and 4. Each of these chapters articulates the dimensions of integration addressed and then provides extensive case material on application to therapy with individuals and couples. The final chapter is an interview with John Clarkin, PhD, a pioneer in integrative approaches to working with individuals and couples.

***—Len Sperry, MD, PhD***

# Biographies

Len Sperry, MD, PhD, is currently clinical professor of psychiatry and behavioral medicine and clinical professor of preventive medicine at the Medical College of Wisconsin, as well as professor of health services administration and psychology at Barry University. Previously he was vice-chair of the Department of Psychiatry and Behavioral Medicine and was professor of family and community medicine at the Medical College of Wisconsin. Dr. Sperry is a diplomate of the American Board of Professional Psychology in Clinical Psychology, the American Board of Preventive Medicine, the American Board of Psychiatry and Neurology, and is a fellow of both the American Psychological Association and the American Psychiatric Association. He is a member of the American Family Therapy Academy, the International Association of Marriage and Family Counselors, the American College of Preventive Medicine, and the American College of Psychiatrists. He is on the editorial boards of *The American Journal of Family Therapy*, *The Family Journal: Counseling and Therapy for Couples and Families*, The Family Psychology and Counseling Series, *Child Psychiatry and Human Development*, and was on the editorial boards of the *Journal of Family Psychology*, *Topics in Family Psychology and Counseling* and *The Family Psychologist*. Dr. Sperry has published 30 professional books—including *Marital Therapy: Integrating Theory and Practice* (1991), *The Disordered Couple* (1998), *The Intimate Couple* (1999) and *Brief Therapy With Individuals and Couples* (2000)—as well as over 200 chapters and journal articles and is on

the editorial board of ten professional journals, including the *American Journal of Family Therapy* and *The Family Journal.* He is listed in *Who's Who in America* and *Best Doctors in America.* He is the originator of Biopsychosocial Therapy and has practiced it and other integrative therapies with individuals and couples for over 30 years.

Jon Carlson, PsyD, EdD, is distinguished professor at Governors State University in University Park, Illinois, and director of the Lake Geneva Wellness Clinic in Wisconsin. He is the founding editor of *The Family Journal: Counseling and Therapy for Couples and Families* and has served as president of the International Association of Marriage and Family Counselors. Dr. Carlson holds a diplomate in family psychology from the American Board of Professional Psychology. He is a fellow of the American Psychological Association and a certified sex therapist by the American Association of Sex Educators, Counselors, and Therapists. He has authored over 25 books and 125 professional articles. He has received numerous awards for his professional contributions from major professional organizations, including the American Counseling Association, the Association for Counselor Education and Supervision, and the American Psychological Association. Dr. Carlson and his spouse of 32 years, Laura, are the parents of five children and grandparents of two.

# Contributors

*John F. Clarkin*, PhD, is a major figure in the development of integrative approaches to psychotherapy. He is professor of clinical psychology in psychiatry at Cornell University Medical College.

*Robert L. Smith*, PhD, is professor and doctoral program director in the Department of Counseling and Educational Psychology at Texas A&M University in Corpus Christi, Texas. He has published broadly on the topic and has a forthcoming book on integrative therapy in preparation.

*William M. Walsh*, PhD, is professor of counseling psychology and director of the Marital Enrichment Center at the University of Northern Colorado. His writings include several articles and case studies on integrative therapy.

PART

# OVERVIEW AND EVOLUTION OF INTEGRATIVE AND BIOPSYCHOSOCIAL THERAPY

# 1

# Dimensions of Integrating Therapy With Individuals and Couples

Len Sperry, MD, PhD

Traditionally, professional training in individual, family, and couples therapy emphasized developing clinical competence in a single theoretical orientation. Such an orientation served to organize clinical information, concepts, and experiences in a way that limited clinical reality to a manageable number of concepts and processes that allowed the therapist to make plausible cause–effect and goals–methods–outcomes thinking and conclusions. Because of this selectivity factor, each theoretical orientation was understood to be necessarily limited and short-sighted. While this single-orientation thinking may have been useful and beneficial in the past, today's increasingly complex clinical realities underscore its limitations and have prompted the search for more comprehensive and integrative approaches to individual and couples therapy.

As this single-orientation view of therapy has been receding, a number of efforts to develop more comprehensive and integrative approaches to therapeutically treating individuals and couples have emerged. The most common method of integration has involved efforts to integrate psychological constructs from two or more therapeutic systems or approaches. One of the earliest of such integra-

tion efforts was undertaken by John Dollard, PhD, a psychoanalyst, and Neal Miller, PhD, a behaviorist. Their goal was to integrate the constructs of classical psychoanalysis with the constructs of behavior therapy. They began publishing the results of these efforts in the late 1940s and early 1950s (Dollard & Miller, 1950).

Generally speaking, theoreticians interested in integration tend to focus on integrating disparate theoretical concepts and constructs, whereas practicing clinicians are more likely to focus on the integration of intervention strategies, techniques, and methods. One of the reasons there has been a proliferation of therapy systems and approaches in the last two decades—numbering about 300 or more—has been the creative combination and integration of various treatment methods and modalities.

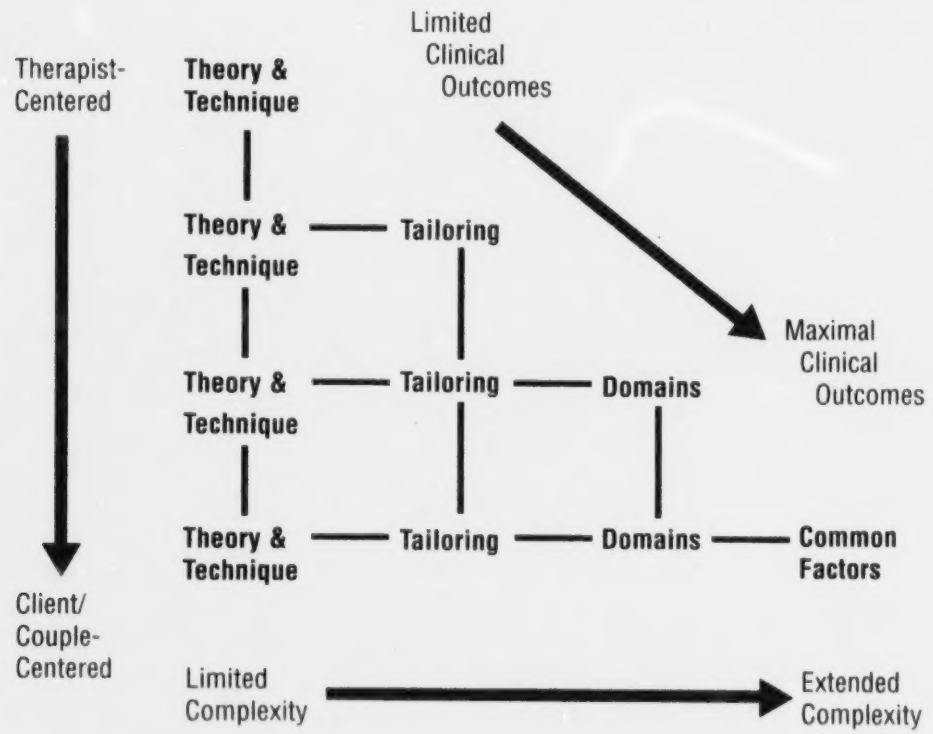
Momentum toward integration in marital and family therapy began slowly and cautiously in the 1970s and has increased dramatically in the past 5 years owing to theoretical developments, economic necessity, and professional need. Theoretical factors include postmodern approaches such as solution-focused and narrative therapy, the refinement of individual and couples interventions, and the recognition of readiness for change and other client factors in the change process. Economic factors include the demands of payers and consumers of therapeutic services for accountability in terms of cost effectiveness and maximizing treatment outcomes. Professional factors are complex and variable and are detailed in a subsequent section of this chapter.

## Levels and Dimensions of Integration

Four levels or dimensions of integration can be articulated: (a) theory and technique, (b) tailoring treatment to client or couple need, (c) domains, and (d) common factors. These levels or dimensions can be differentiated in three ways: (a) in terms of complexity, (b) in terms of degree of therapist or client/couple-centeredness, and (c) in terms of clinical outcomes. Figure 1.1 illustrates these three ways.

Each level is increasingly more complex than the previous level. Similarly, each subsequent level is more client- or couple-centered than the previous level. Finally, it could be expected that each subsequent level has the potential for maximizing treatment outcomes than the previous levels. For instance, a third-level integrative treatment approach that includes integration of theory and technique along with two or more domains and tailoring of treatment in terms

**FIGURE 1.1**
**Levels and Dimensions of Integrative Treatment**




of client need (i.e., level of distress, such as that developed by Robert L. Smith as described in chapter 3 of this book) would be expected to have a higher level of complexity, to be more couple-centered, and to lead to increased treatment outcomes than a treatment approach that simply involves integration of theory and technique, such as Nichols's (1988) integrative approach to marital therapy.

### *Integration Based on Theory and Technique*

The first level of integration, as noted earlier, involves integration of theoretical constructs, therapeutic interventions, or both. There have been various efforts to integrate marital and family therapy approaches in the past two decades. Most notable are Feldman's (1992) integrative multilevel family therapy approach, Nichols's (1988) integrative approach to marital therapy, and Will and Wrate's (1985) problem-centered, psychodynamic family therapy approach. All of these efforts combine two or more treatment sys-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tems. These and other efforts to integrate theory and technique are described in chapter 4 of *Family Therapy: Ensuring Treatment Efficacy* (Carlson, Sperry, & Lewis, 1997).

A more conceptually sophisticated approach to integration of theory and technique emphasizes the core constructs and techniques common to *several* couple and family treatment systems, rather than two or three systems. Doherty, Colangelo, Green, and Hoffman (1985) attempted such an effort. They contended that all couples' relationships can be characterized in terms of three meta-constructs that essentially combine and integrate concepts and principles of most marital and family therapy approaches. These three constructs are boundaries or inclusion, power or control, and intimacy. These three meta-constructs are briefly described.

*Boundary issues* in couples are those that center around membership and structure: membership in the sense of who is involved in the marital system and to what degree; structure in terms of the extent to which each partner is part of but at the same time apart from the couple subsystem. Boundary issues also refer to interpersonal boundaries, specifically the degree of intrusiveness that will be accepted in the relationship. For a couple, commitment to their intimate relationship is a core boundary issue, as is the partner's relative commitments to jobs, extended family, friends, and other outside interests, whereas at the same time having a sense of being recognized as an individual. In terms of couples therapy approaches, the structural approach (developed by Minuchin, 1974) and the contextual approach (advoc[illegible]ed by Boszormenyi-Nagy & Krasner, 1986) emphasize the inclusion or boundary dimension of couples functioning. Such therapeutic efforts are primarily directed at assessing and intervening in the boundary and role patterns to modulate the extent of enmeshment and distancing within the relationship as well as intergenerational boundaries (Doherty et al., 1985).

*Power issues* include responsibility, control, decision making, and role negotiation. Couples' interactions continually involve overt as well as covert attempts to influence decisions and behavior. Control or power issues are typically tied to issues of money, reward, and privileges. They also manifest themselves in more subtle ways, such as escalation of conflict or one-upmanship in efforts to regulate the partner's behavior. Couple interaction also involves struggle for control of the relationship in various ways. Essentially, the basic dynamic in marital conflict involves who tells whom what to do under certain circumstances. Couple interactions range from positive to negative emotionally, and from laissez faire to democratic to autocratic politically. Thus, power becomes a meta-rule for all de-

cisions about boundaries as well as intimacy. It determines which partner will pursue and which will distance, as well as how this is accomplished. In terms of couples therapy approaches, the strategic approach (advocated by Haley, 1976), the interactional approach (developed by the MRI Group; Watzlawick, Weakland, & Fisch, 1974), and the behavioral system (such as described by Jacobson & Margolin, 1979) emphasize this power and control dimension of couple functioning. These therapeutic approaches focus on changing the couple's rule system for mutual regulation. This can be accomplished directly, by teaching a feuding couple communication and problem-solving skills, or indirectly, such as with a paradoxical prescription to neutralize a specific power struggle (Doherty & Colangelo, 1985).

*Intimacy issues* for couples are evident in areas such as self-disclosure, friendship, caring, and appreciation of individual uniqueness: Intimacy involves negotiating emotional as well as physical distance between partners or among family members. In either instance, the goal is to balance a sense of autonomy with feelings of belonging. When issues of affection become a source of difficulty, they can be manifest in various ways, ranging from complaints such as "You don't understand my feelings" to "I'm being taken for granted" to "The romance has gone out of the relationship." In terms of couples therapy approaches, the psychoanalytic and object relations approach (such as the approaches of Ackerman, 1984), the symbolic–experiential approach (described by Whitaker & Burnberry, 1988), and the humanistic–communications approach (advocated by Satir, 1964) emphasize the intimacy dimension in couples. These approaches place a premium on optimal couple functioning and self-differentiation.

Resolving issues of boundaries and control is viewed as a prerequisite to helping partners relate in a healthy, intimate fashion (Doherty & Colangelo, 1985). Because these meta-constructs of boundaries, power, and intimacy are broad and inclusive, they can be quite useful in assessing and formulating treatment issues with couples.

### *Integration Based on Tailoring Treatment to Client or Couple Need*

A second level of integrating treatment involves tailoring treatment to a client's or a couple's need. Tailoring is a process of modifying a treatment intervention or approach to "fit" a client or couple so that they are more likely to benefit from the intervention. Ob-

viously, tailoring requires that the focus of treatment be on the client or couple need rather than the therapist orientation or need. Hence it is more demanding than integration based on theory and technique.

There are several ways of tailoring treatment to an individual's or a couple's need. Among these are (a) level of individual and couple functioning, (b) level of relational conflict, and (c) level of couple distress. A detailed description of these and other approaches to tailoring treatment can be found in chapter 5 of *Family Therapy: Ensuring Treatment Efficacy* (Carlson et al., 1997).

### *Integration Based on Domains*

A third level of integration is based on domains. Domains refer to categories of experience and explanation, such as the biological or physical, the social and cultural, the spiritual, and the psychological domain. Traditionally, individual therapy approaches have emphasized the psychological domain, family therapy has emphasized the social domain (i.e., family systems dynamics), and medicine has emphasized the biological domain. Yet, there have been some exceptions. Perhaps the most notable has been psychosomatics, now called mind–body medicine or psychology, in which explanations for behavior included both the psychological and biological domains, or the *biopsychological domain*. Some couples therapists focus on the psychosocial domain by focusing on both personality dynamics and systems dynamics. Similarly, concern for multicultural factors in the treatment of individuals and couples is a current example of the *psychosocial domain*, as culture is a significant aspect of the social domain. Another exception is the marital and family therapy approach to the treatment of eating disorders in a spouse or a family member in which treatment is directed to both the biological and social (i.e., family dynamics) domains, called the *biosocial domain*. More comprehensive efforts directed to eating disorders that focus on the psychological domain, in addition to biosocial domain, are referred to as the *biopsychosocial domain*.

One of the most valuable treatment approaches that attends to the three domains, as well as the integration of several treatment modalities and techniques, is Lazarus's (1981) multimodal therapy. This approach is based on the BASIC-ID factors, including four psychological factors, Behavior, Affect, Sensation, and Cognition; one social factor, Interpersonal; and one biological factor, Biology/Drugs. Although Lazarus has not formally articulated his approach

as focused on biopsychosocial domain, it clearly is. The case examples he cited of individual and couples therapy cases suggest the clinical value of this approach where other less comprehensive and integrative approaches have failed.

The biopsychosocial domain proposes that an individual or couple can only be adequately understood if the therapist considers the biological and social domains along with the psychological domain. Physical functioning refers to all peripheral organ system functions as well as to all autonomic, neuroendocrine, and central nervous system functions that are subcortical, that is, to all processes that are automatic and outside conscious awareness. Psychological functioning refers to the self-conscious inner world that directs information processing and communication from and with the outside world. It basically involves cortical structures and conscious awareness. It also includes the internal representation of self, the world, and personal goals, which reflects aspirations, ideals, needs, and the cognitions and strategies that govern behavior. The social functioning refers to the person's behavior in relation to family, friends, authorities, peer group, and cultural expectations, as well as community institutions that influence and are influenced by the individual. It may be that a truly comprehensive or holistic approach would also include the spiritual domain, which would be referred to as the *biopsychosociospiritual domain.*

It would seem reasonable that the more domains involved in the integration effort, the more sophisticated the integrative explanation and treatment effort will be. Accordingly, a biopsychosocially oriented therapy would seem to be not only more comprehensive but also more demanding of the therapist. It would be more demanding of the therapist in that the biological and sociocultural domains, in addition to the more familiar psychological domain would have to be addressed in terms of assessment and possible interventions. So, what incentive exists for psychologists and marital and family therapists to adopt a biopsychosocial approach? It appears that shifting practice patterns account for this recent development. For example, in endeavoring to extend the scope of practice for psychologists, the American Psychological Association (APA) has recently designated professional psychology as a primary health care specialty in order to be eligible for Medicare reimbursement and federal training grants. As a corollary, the APA adopted the biopsychosocial model as the basis for planning and implementing therapeutic interventions. A related development has been the movement of individual, couples, and family therapists into primary-care medical settings.

A final comment about this third level: There are undoubtedly many counselors and therapists whose practice reflects some degree of integration at this level of domains although they may not formally articulate this fact. Certainly, couples therapists who focus on both personality dynamics and systems dynamics are practicing at both domains. Although there have been some publications describing integrating individual dynamics with systems dynamics (Wachtel & Wachtel, 1986), there appears to be a well-defined chasm between these two sets of dynamics. Furthermore, it appears to be politically incorrect to attempt to bridge this chasm, which may account for the hesitancy of writers to articulate this level of integration.

### *Integration Based on Common Factors*

A fourth level of integrating treatment intervention is to integrate clinical research findings with clinical practice. This may seem to be somewhat of an oxymoron in that seasoned clinicians typically believe that psychological research has little or no relevance to their clinical practice. There are, however, some recent research findings that appear to have extraordinary clinical relevance in integrating psychotherapeutic interventions.

On the basis of his review of several psychotherapy outcome research studies, Lambert (1992) described four common curative elements central to all forms of psychotherapy, including individual, group, family, or couples therapy. These four factors are (a) client resources, (b) therapeutic relationship, (c) intervention strategies and tactics, and (d) faith, hope, and expectancy (Lambert, 1992).

*Client resources* refer to those factors, beyond symptoms, stressors, or personality and character structure, that significantly impact the outcome of therapy. Whether treatment outcomes are positive or negative largely depends on the presence or absence of specific "client resources." In fact, it is estimated that client resources account for about 40% of the improvement that occurs in any treatment (Lambert, 1992). Client resources are defined as those internal and external resources clients, and couples bring to therapy that affect change in therapy *irrespective* of participation in the treatment process. Inner resources include the client's or couple's readiness for change, coping and personal/social skills, motivation, ego strength, intelligence, achievements, psychological-mindedness, courage, and past history of success in change efforts. External resources are specific environmental resources that impact the client, such as social support system, financial resources, and even fortuitous events.

The *therapeutic relationship* is the context in which the process of therapy is experienced and enacted. It is estimated that about 30% of the variance in psychotherapy outcome is due to relationship factors as compared with 40% that is attributed to client resources (Lambert, 1992). It appears that the quality of a client's or couple's participation in the therapeutic relationship is the essential determinant of outcome and that clients and couples who are motivated for, engaged in, and collaborate in the treatment process with the therapist are most likely to benefit from the experience. Furthermore, when clients and couples feel understood, safe, and hopeful, they are more likely to take the risk of disclosing painful affects and intimate details of their lives, as well as risk thinking, feeling, and acting in more adaptive and healthier ways.

*Intervention strategies and tactics* have traditionally been thought not only to be the defining features of a given therapy approach but also as the critical factors in the change process. Unfortunately, a meta-analysis of several research studies on individual, group, and couples therapy indicates that specific intervention methods have only a minimal effect. Lambert (1992) estimated it to be only about 15% of outcomes of treatment.

The final factor encompasses *faith, hope, and expectancy.* The remaining 15% of the variance of individual or couples therapy is attributed to this phenomenon, known as the placebo effect, the faith factor, hope, or the expectancy effect. It is that proportion of treatment outcomes related to the client's or couple's belief in the therapist and their belief in and hopefulness about the efficacy of the specific treatment to make a difference in their lives. Benson (1996) labeled this phenomenon the faith factor and noted that an individual's belief in the cure or in the clinician who provides the cure has healing or curative power. Related to this belief are specific expectations about how, when, and why change will occur. Research indicates that simply expecting therapy to be helpful somehow reverses demoralization, mobilizes hope, and facilitates improvement (Frank & Frank, 1991). In other words, fostering a positive expectation for change appears to be a prerequisite for successful treatment.

This fourth level of integration is clearly one of the last remaining challenges for development on the therapeutic frontier. The concerted efforts to integrate these common factors in individual psychotherapy (Hubble, Duncan, & Miller, 1999; Miller, Duncan, & Hubble, 1997) have yet to be matched in either family therapy or couples therapy. It is our hope that this book will begin this integration, at least within the couples therapy literature.

## Overview of the Book

In chapter 2, William M. Walsh describes a unique and sophisticated integrative approach that primarily emphasizes the integration of theory and technique. Several theoretical systems and techniques are integrated, including the structural approach, the communications approach, the cognitive–behavioral approach, the solution-focused approach, and the narrative approach. In addition, it incorporates the dimension of tailoring.

In chapter 3, Robert L. Smith describes another integrative approach for the treatment of couples and individuals focused at two levels of integration. The first involves the integration of theory and technique. Four approaches are integrated: the structural approach, the cognitive–behavioral approach, the solution-focused approach, and the psychoeducational approach with its emphasis on intersession assignments or homework. Tailoring is the second level of integration. A clinically useful taxonomy is provided to indicate optimal treatment applications.

Biopsychosocial therapy is the focus of chapter 4. It is a type of integrative therapy applicable to a broad cross-section of individuals and couples, particularly those with concurrent health-related or medical issues. As such, it has considerable value for therapists and counselors practicing in health care settings or when individuals and couples present with health-related concerns or factors. It describes an approach to therapy that involves all four levels and dimensions of integration. In addition to focusing on the biopsychosocial domain and integrating theory and techniques, this approach tailors treatment based on client/couple levels of functioning and distress, as well as emphasizing the common factors of therapy, particularly client resources.

Finally, in chapter 5, John F. Clarkin, who has made major contributions to the literature on integrative and biopsychosocial approaches to therapy, reflects on a number of issues and developments in the biopsychosocial and integrative approaches to the treatment of individuals and couples.

## Summary

The purpose of this chapter was to situate both the increasing economic and professional need for integrative treatments as well as the current status of the integrative therapy approaches. It briefly described four levels and dimensions of integration applicable to

individuals and couples: theory and technique, tailoring, domains, and common factors. Finally, it provided an overview of the remaining chapters in the book.

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■■■

PART II

# APPROACHES TO INTEGRATIVE AND BIOPSYCHOSOCIAL THERAPY

# 2

# Integrative Family Therapy for Couples

William M. Walsh, PhD

Therapy begins with a search for the meaning of human behavior. The therapist asks: "Why is this individual or couple experiencing enough anxiety or dysfunction to cause them to seek help or to be compelled by others to ask for assistance?" All therapists who develop therapy models have beliefs or concepts that explain the human condition. Whether these are cognitive, affective, historical, or systems based or some combination of these, they all attempt to understand behavior so that appropriate interventions can be developed.

Integrative family therapy (IFT) was developed in 1975 for use with individuals, couples, and families. It is an integration of several components of major family theorists, principally Virginia Satir, Salvador Minuchin, Alfred Adler, and Steve deShazer, and traditional ideas of individual personality development into one consistent model. As with most theoretical models, IFT has changed somewhat in the past two decades, incorporating more of the postmodern ideas and techniques and decreasing the emphasis on intrapsychic dynamics. For the purpose of this chapter, the focus is primarily on individuals and couples. In reality, however, it is sometimes difficult to separate individual and adult couple issues from parental or family issues. Therefore, the discussion in this chapter at times addresses parenting and child concerns.

## Theoretical Tenets

To identify functional and dysfunctional aspects of couples, one must discuss characteristics that all systems have in common. These characteristics are the ways and means that all individuals attempt to carry out their functions and meet their stated and unstated goals. The discussion starts with general characteristics that are considered to be universal and concludes with specific dynamics that relate directly to health and illness in individuals and couples.

## General Concepts

The following seven broad statements should give the reader a feeling for the philosophical position of IFT.

1. Individuals and couples are systems. They are networks of specific interrelated and interdependent parts. Each person, as well as groupings of individuals, is a part of the whole and a separate part of the system. For example, the husband is one part of the system because he is in the couple unit. But he may also be a second part of the system if he is a father in the parent subgrouping.
2. The natural process of growth and development causes each part of the system to change. Even a slight change in any one part necessitates a change or realignment in the other parts. One can imagine the ramifications in a system if any one of its parts experiences a major change. If the therapist is to truly understand and monitor the inner workings of the unit, he or she must be especially attuned to two facts: the multiplicity of parts and the potential or actual consequences of change.
3. Individuals and couples are significantly influenced by aspects of their unique heredity and environment. Heredity refers to all innate biological elements of a person that are attributable to the genes of the parent. The environment is composed of all factors, apart from genetic elements, that influence the growth and development of the individual. Society's reactions to ethnicity, race, and socioeconomic levels are significant parts of the environment.
4. All behaviors, attitudes, values, and feelings can be both rational (enhancing) or irrational (dysfunctional) to the individual or the couple system. The context in which they are expressed is the determining factor. In one situation, a person's overt aggressive behavior may be totally inappropriate and consid-

ered to be unhealthy (e.g., at work). The same behavior in a different context may be interpreted as an appropriate response (e.g., in an athletic contest). The key point is that behaviors, attitudes, values, and feelings do not possess inherent worth in and of themselves. They cannot be adequately understood out of context.

5. Homeostasis is a desired state for all individuals and systems. As needs arise, tension is produced in the organism. The satisfaction of those needs reduces the tension and returns the system to a more balanced state. Thus, it is ideal if needs are appropriately satisfied and a comfortable balance is achieved. When needs are left unsatisfied, the tension remains in the system. Homeostasis is not achieved, and the organism must find other alternative ways of returning to the balanced state. The goal of most alternative methods is to reduce tension, not to satisfy needs. Therefore, frequently, these alternative methods are dysfunctional because they do not lead to the satisfaction of the original need. Neuroses and psychoses are common ways for individuals to achieve a temporary balance without actually satisfying the original need. Symptoms such as phobias, conversion reactions, and depression are examples of unhealthy mechanisms.
6. All behaviors of an individual or a system are attempts to preserve and enhance the organism. The goal is never to destroy. The result may be self-destructive, but the intent is always growth. With this in mind, all debilitating and harmful behaviors, attitudes, values, and feelings are distorted or misdirected attempts to save or to help the system. In other words, no organism has the capacity to willfully and knowingly produce self-destruction.
7. All systems have the capacity within themselves to solve their own problems. They seek help because the individual or couple is caught in repetitive patterns that blind them to new ways of acting. It is the therapist's role to identify stuck points and assist the clients to identify new solutions. This process is the core of teaching the clients to have a more satisfying problem-solving process.

## Specific Tenets

The following five specific tenets are the means by which the therapists develop their diagnostic picture of the couple. This evalu-

ation should lead to an individualized treatment plan for the couple, consisting of treatment goals, working hypotheses, and intervention strategies. Everything that is done in therapy should relate directly to these five specific characteristics.

### *Family Structure*

The first concept is a modification of the structural model developed by Minuchin (1974) and comprises subsystems and boundaries. Subsystems are groupings of individuals in the system and are organized around tasks or functions. Individuals, usually adults, decide who will participate and who will be excluded in the subsystems. Any combination of members is allowed, particularly if their presence is viewed as important for the fulfillment of functions. IFT concentrates on three major subunits of the family: marital/adult, parental, and sibling.

The marital/adult subunit is composed of adult family members who are bonded together by emotional, sexual, or economic factors. It may encompass relationships involving the husband and wife in a nuclear or remarriage family or the single parent alone or with a partner. This subunit is the source of adult need satisfaction in the functional family. It is the adult support unit. In the troubled family, it is frequently the arena of conflict, revenge, or avoidance. Typically, marital and sexual problems surface in this subunit. These conflicts may or may not affect the other subunits, depending on the type of boundaries that exist in the system.

The parental subunit is the governing body of the system. It is the source of decision making, goal setting, and the nurturance for the entire unit. This subunit usually consists of the mother and father or any surrogate for these roles (e.g., stepparents, grandparents, or adult children). In single-parent families, the parental subunit may consist of only one adult. However, that parent may enlist the aid of another person to share the functions of this subunit. A grandparent or older child may be included temporarily or permanently to help with the parenting and decision-making functions. The parental unit functions best when the adults work as a team, communicating and coordinating their needs and wishes to accomplish the tasks of the unit. They are the executives in the family. It is important that they mutually guide the family without undue outside interference. The therapist will closely observe the workings of the parental team and note how the adult subunit supports or negates parenting functions.

The sibling subunit is populated by the children. This subunit is, in a sense, the training ground of the family. In a functional

family, the sibling unit provides education, support, and guidance appropriate to the developmental levels of the individuals involved. Ideally, this subunit helps to produce responsible and functional adults.

Boundaries are an integral part of the structure. They should allow input from the outside world, yet protect the couple from unwarranted influences. There are three kinds of boundaries: clear, rigid, and diffuse. The clear boundaries allow two-way flow of information and activity between the couple and the outside world. Diffuse boundaries provide little protection from individual members or from outside forces; these unhealthy boundaries create overinvolvement or enmeshment inside the system or with outsiders. Rigid boundaries provide maximum protection yet they shut out any influence from the outside; the result for the couple is isolation and disengagement. The construct of clear, diffuse, and rigid boundaries also applies to the subunits inside the family. Clear boundaries between subunits and the individuals involved are considered to be the most functional arrangement. Clear boundaries are advantageous for the creation of mutuality and privacy, as well as the development of independence. Diffuse and rigid boundaries are always considered to be dysfunctional, except as temporary therapeutic strategies to effect change in the structure of the family.

### *Communication and Perception*

The second concept, communication and perception, is a modification of the work of Satir (1967), who emphasized communication and perception as a total process. She did not specifically isolate the perceptive aspect as a source of dysfunction or as a focus of remediation. IFT discusses communication and perception as a two-part process. The integrative therapist's emphasis is particularly intensive in regard to the perceptive element of the communication process. In fact, faulty perception is considered to be a more common problem for families than is miscommunication.

The concept of communication and perception is perhaps the most important of the relationship dynamics because it pervades every personal interaction. All overt and covert human behavior involves communication and perception. We cannot survive in the world at any level of existence without communicating and perceiving on a moment-to-moment basis. None of the other characteristics can operate to their maximum capacity without accurate and clear communication and perception. They are the eventual focus of almost every therapeutic encounter. The counselor may

initially choose to work with structure, create greater role responsibility, or resolve a negative theme. But eventually, the concept of communication and perception will be an item of discussion and possible intensive intervention. In most cases, to maximize the fulfillment of functions, a couple will need to make changes in their communication–perception process.

Communication is the transmission of a message in any verbal or nonverbal manner. It is one aspect of a two-part process. Perception is the act of receiving that message. Perception has two parts: listening to the verbal or nonverbal message and understanding the implicit or explicit message. Thus, it is a different aspect of the process and must be considered separately when the therapist is evaluating the complete communication–perception process. Clear communication is possible without accurate perception, but the reverse is difficult to achieve.

For example, a wife may send clear and concise messages to her husband. Yet, the husband may perceive these messages in an inaccurate and distorted manner, possibly because of his defensiveness. In this case, it is not the wife's communication that must be the focus of intervention but, rather, the husband's perception. A breakdown occurs in perception, which is the second part of the process. Thus, perception itself (e.g., defensiveness) can be the object of the therapist's energy. Asking the communicator to change his or her method of transmission may be ineffective or even counterproductive. The emphasis should be on more accurate perception by this one individual. However, if the problem is the transmission of mixed, double, or confused messages, the focus of the intervention is quite different. By identifying the dysfunctional element—communication or perception—a more accurate strategy will ensue.

Research data on the IFT model indicate that faulty perception is a more significant element in dysfunctional couples than is faulty communication. According to this research, faulty perception occurred in 90% of the treatment couples assessed. Poor communication was present in approximately 50% of the couples in treatment (Walsh & Wood, 1983). This being the case, an IFT counselor should be more aware of each person's perceptions, thereby possibly designing interventions to remediate the specific problem.

Most couples have consistent, characteristic methods of communication. They have an established process that varies little from incident to incident. Thus, if they are communicating inaccurately, the communication usually occurs the same way each time. To identify the patterns, the therapist can pose several questions: "How do

each of you communicate with one another?" "How do individual members communicate with outsiders?" and "What are the channels of communication?"

Individuals may communicate and perceive differently within their family from the way they do with outsiders. Differences can more often be seen with communication than with perception. On the one hand, if an individual is perceiving inaccurately with family members, this problem is pervasive throughout all of his or her contacts. Accurate communication, on the other hand, can vary from situation to situation. Channels of communication refer to the individuals or groups that are usually involved in an interaction. If the sibling subgroup is communicating with the parental unit, which parent is usually chosen? Or are both chosen? When do the siblings go to Dad? When to Mom? Who handles communication with the school? Each situation may have to be explored depending on the major themes that are presented or on the roles that are established in the family. As the therapist and couple interact, the therapist can begin to pinpoint specific incidents. Thus, it is possible to recognize patterns in the therapy sessions. This reorganization usually occurs concurrently with other goals of therapy.

### *Role Responsibility*

The third concept is role responsibility. A role is defined as the identity that an individual assumes, on a temporary or permanent basis, to complete certain tasks. A role, therefore, is a set of general and specific expectations that are accepted by or ascribed to each individual. These expectations may involve specific duties that must be performed on a regular schedule or they may be a general way of behaving with others. Because the completion of tasks is essential for a system to fulfill its various functions, appropriate expectations (role definition) and follow-through are particularly critical characteristics. Role responsibility is considered appropriate when a certain sequence of events is followed. That is, when role responsibility is observed, individual expectations are clearly defined and articulated by the family. The role responsibilities are age appropriate and realistic for the individual. All members contribute to the definitions of their roles. In addition, each member accepts responsibility for his or her assigned duties. If the expectations are fulfilled, there are positive emotional, physical, or material consequences. When the expectations are not followed through, there are negative consequences. These may take the form of timeout or the removal of privileges for children. For adults, the consequences

are usually more subtle, such as the withdrawal of affection, or more insidious, such as emotional or physical abuse.

The sequence of expectations, follow-through, and consequences is called the responsibility process (see Figure 2.1). It is considered to be critical in the healthy development of individuals and couples.

A breakdown in any part of the process will eventually make it difficult, if not impossible, to fulfill functions. At the very least, individuals will be dissatisfied with their own or others' behavior. The process involves all family members, whether adult, adolescent, or child, and relates directly to one of the major problems for couples, namely, role irresponsibility. The lack of clearly defined and articulated expectations for individuals is a leading cause of disruption. Certain behaviors may be assumed or taken for granted without ever being articulated. In other words, individuals do not know what they should be doing or how they should be doing it. Any or all members can be placed in this position. A married woman may not know what her husband considers to be a "good wife" (according to their personal definition of "good wife," of course). She may do what she considers best but is frustrated and unhappy with her husband's negative reactions. The expectations are too general. They have probably not been discussed by the pair.

Parental attitudes about child rearing also fall into this category. Some parents feel that they are doing their children a favor by not giving them age-appropriate duties or by not requiring them to follow through on assigned tasks. These children are being raised as pampered, irresponsible children. The child's learned attitude and behavior usually carry over into the classroom and social activities.

Another more insidious problem with roles involves the ascribing of individual roles, labeling of individual members, or scapegoating. By definition, these three issues involve a lack of consent on the part of the individual. In this situation, a role, involv-

**FIGURE 2.1**
**Responsibility Process**

| Expectations | Follow-Through | Consequences |
|---|---|---|
| clear | complete | clear |
| mutual | | mutual |
| realistic | | realistic |
| specific | | specific |
| consistent | | consistent |

ing certain expectations, is given to an individual without choice or input. That person is then expected to follow through on the expectations. If he or she is unsuccessful, negative consequences will result. This situation is one of the most resistant to therapeutic effect.

Generally speaking, role irresponsibility is a result of one or more of the following:

- Incomplete or general expectations
- Poorly articulated expectations
- Lack of personal input about expectations and consequences
- Inconsistent completion of expectations
- Lack of clear, appropriate consequences
- Ascribing, labeling, or scapegoating

### *Family Themes*

The fourth concept involves family themes. A theme is defined as any issue that occurs frequently for a couple and that absorbs a significant amount of interest and attention. These issues can be positive (growth enhancing) or negative (counterproductive or destructive). Issues are related to the psychoanalytic concept of the repetition compulsion. Positive themes involve the couple in constructive activities that usually lead to growth for everyone and are characterized by the early resolution of conflicts and the healthy channeling of tension toward goal accomplishment. Positive themes also demonstrate resilience in problem solving. Athletic pursuits, intellectual or cultural activities, and home maintenance are common examples of positive themes.

Negative themes, on the other hand, are characterized by nonresolution of conflict and increased tension. Whenever a particular issue related to the negative theme surfaces in the couple, it creates disharmony and unhappiness. When negative themes are allowed to persist, the couple or individual members are faced with unresolved conflicts that tend to multiply. The accumulation of these conflicts over many years can produce an irreconcilable situation. Individuals may decide to dissolve their relationship rather than work on seemingly insurmountable lists of grievances and conflicts. Common examples of negative themes include unsatisfactory personal or financial achievement, role irresponsibility, differences in child-rearing practices, and different attitudes about financial behaviors.

All couples have several identifiable, major themes. These themes occur on a regular basis. Each usually involves similar dynamics

when it reoccurs. Thus, for the couple, major themes are like listening to the same record played many times. For negative themes in particular, the couple is caught in a rigid pattern, compelled to repeat the same actions. In their experience of the situation, individuals have little choice in how they will behave. As a result, they seek few alternatives. In the case of positive major themes, the couple/family may choose to respond in a similar pattern each time the issue occurs. The difference is that members choose the behaviors because of the pleasure and growth the behaviors bring. Individuals are not forced into patterns because of rigidity or absence of alternatives.

The therapist should attempt to identify the major positive or negative themes as soon as possible. Usually, several themes surface in the first two sessions. Negative themes generate the initial therapeutic goals for change. Negative themes involve those issues that are most troublesome for the couple on a daily basis. Resolution of these themes gives the couple a greater hope for the continued change. In other words, the resolution of initial themes positively disposes the family to work on other more resistant problems.

The feeling of relief that short-term change can produce may lead the couple to premature termination. The therapist must be aware of this and work to counteract it from the first session. It appears that there are a limited number of negative themes in most couples. Even in severely unhealthy situations, three to five negative themes are the norm. Also, positive themes should not be ignored or forgotten. It is important for the couple to see positive aspects of themselves while they are working to resolve negative themes.

### *Individual Personality Dynamics*

The fifth concept, personality dynamics, refers to those strategies that an individual uses to organize, understand, and complete the tasks of daily living. Personality dynamics are the overt and covert means used for personal need satisfaction. Functional means lead to feelings of comfort and well-being (i.e., tension reduction). Dysfunctional dynamics distort or avoid reality in an attempt to attain immediate tension relief. Dysfunctional dynamics fail to satisfy the original need.

Including the concept of individual personality dynamics in IFT is a departure from the theories of most major systems models, although several theorists attempt to account for individual psychologies in their formulations. Ackerman (1966), Kramer (1980), and Schwartz (1987), for example, consider individual members to

have personality dynamics that influence the couple. These theorists believe that the intrapsychic phenomenon for each member affects the interpersonal processes in the unit. However, each of these theorists has a specific theory of personality to understand and diagnose each member. The IFT therapist also values intrapsychic phenomena but feels that any individual model of therapy may be used in conjunction with the four relationship concepts. If this theory is to be useful to a variety of practitioners in different settings, why limit the choice of an intrapsychic model to one theory? IFT offers the flexibility of choosing the individual model that best fits the individual therapist's philosophy of life.

Students of individual therapy models are familiar with the various explanations that theorists use to explain behavior. The IFT counselor may choose any individual theoretical model. This flexibility is a particularly attractive option for the experienced therapist, who already has a well-developed personal model for understanding and treating individual problems. Thus, the options available to the IFT therapist for using various personality theories mean that a therapist may make a smooth transition from treating individuals to treating couples. IFT therapists have used a number of the major individual models, including rational–emotive, Adlerian, behavioral, reality, phenomenological, and dynamic models.

The particular model chosen is less important than the fact that the therapist has a model for understanding intrapsychic dynamics. In some therapeutic situation, it is essential for the integrative therapist to have an understanding of each member's behavior to gain a complete diagnostic picture. It is important that the therapist have specific concepts for understanding individual behavior that are complementary to the concepts of family dynamics. Some IFT therapists choose to blend several intrapsychic models into an eclectic approach to understand the individual.

When the therapist begins to analyze the individual personality dynamics, he or she should consider the adults first. In couples therapy, the adults are the only focus of the assessment. They are the architects of the family. Thus, they have, in a sense, created some of the personality dynamics of their children. They are also the carriers of the dynamics from their own families of origin. For instance, a husband's way of dealing with aggressive male behavior may be different from his wife's because of different circumstances of their development in the family and society. Much spousal and parental behavior can be understood from an analysis of individual personality dynamics that were internalized by the husband and wife from their own families.

Individual dynamics are not significant factors in all therapeutic situations. Originally, they were central to change in approximately 50% of the couples seen in therapy. As the model and field evolved over the past three decades, individual dynamics have become less important. Today, approximately 10% of the couples present significant intrapsychic dynamics that interfere with the usual systemic interventions.

These five concepts constitute the theory of personality of IFT. They represent the theoretical framework of the therapist from which all change strategies will emanate. All of the therapist's interactions with a couple/family will be guided by the hypotheses generated from these constructs. The therapist can gain a relatively complete diagnosis in two to three sessions. Information gained in these initial sessions is organized into the five categories. The therapeutic goals and methods of intervention are based directly on this five-part diagnostic picture. Much of this information will be shared with the couple. Their involvement in the process will be solicited by the therapist. A mutually motivated change process can then begin.

## Therapeutic Process

IFT for couples is a well-defined and structured process with a mean duration of 10 sessions. It has specific stages, and each stage has certain tasks to accomplish. The therapist organizes the therapeutic encounter according to these stages and tasks, moving through them in an orderly fashion toward successful termination. Thus, this theoretical process provides direction for the therapist. Guideposts along the way help the therapist to evaluate the couple's progress. In actual practice, stages overlap and blend into one another as sessions flow from person to person or from topic to topic. The therapist might move from Stage 1 to Stage 2 and into Stage 3 in a matter of minutes. He or she may then have to circle back to Stage 1 to complete a structuring task. In other words, the live session does not always fit the organized theoretical pattern. Even so, for the IFT therapist, the theoretical pattern is essential for providing structure to a potentially disorganized and chaotic presentation of ideas, feelings, and behaviors. A couple in conflict under varying degrees of tension and anxiety does not have the capacity to rationally evaluate what each member is saying, feeling, or doing. Nor can the members, under stress, take steps to remediate the situation. The therapist, with an organized theoretical process, does

have the capacity to impose order, establish goals, and chart future directions. The point is that he or she has the cognitive structure of a theoretical process for a guide in each session.

The theoretical therapeutic process of IFT consists of five relatively distinct stages: structuring, observation and assessment, intervention, change maintenance, and review and termination. Each stage, discussed below, has specific tasks that must be accomplished before the couple can effectively move to the next stage. Thus, the stages are developmental, in that, for each stage, the therapist prepares the couple to move toward the tasks in the next stage.

### *Goals of the Process*

The five stages are organized so that a couple can progress in an orderly fashion to accomplish the two major goals of IFT. These are

1. To remediate specific immediate difficulties and concerns of individuals.
2. To build a satisfying problem-solving process that individuals and couples can use to deal with future problems.

These two goals reflect the twofold emphasis of IFT. Of initial importance is the resolution of present difficulties or crises that are sapping the day-to-day energies of the couple. Setting and accomplishing short-term goals prepare and motivate the couple to develop a more functional lifelong problem-solving orientation. Success in present-day problem-solving inspires confidence and trust in the couple's future potential. The removal of pain and the reduction in daily conflicts free the couple to devote more energy to long-range plans. IFT's two goals are present in the mind of the therapist from the first session. The goals give the therapist direction from week to week.

### *Stages in Therapy*

***Structuring.*** The therapist asserts control from the beginning of the first session. This is not an authoritarian type of situation. It is instead an encounter between a professional with certain skills and a group of individuals who seek assistance regarding certain problem situations. It is a consultative type of relationship, which is analogous to that of an architect and a home builder or an accountant and a client. The therapist is employed by the couple to

assist in finding solutions to their individual and joint problems. It is never a power-related or adversarial relationship. The professional, by virtue of specific training and experience, has certain skills that are needed by the client. It is not a personal, social, or mystical relationship. In a sense, it is a businesslike arrangement that happens to involve intensely personal ideas, feelings, and behaviors. This is not to say that the therapist must be isolated and coldly analytical. On the contrary, mutual feelings of warmth, acceptance, and caring are essential for a productive and therapeutic encounter. The therapist is in a unique and difficult position. He or she must maintain objectivity and separateness, yet at the same time, he or she is including himself or herself in the human drama of each couple's life. Establishing and maintaining this type of relationship is the first challenge of therapy.

By exerting initial control, the therapist instills confidence and optimism in the clients regarding the potential for change to occur. There is order and stability in the clients' lives, at least when they are in session. The therapist's behavior also provides role models for individuals to emulate in the session and in their outside contacts.

To establish control, yet promote an accepting, cooperative atmosphere, the therapist has several critical tasks to accomplish in the first session. First, he or she should be firm about the overt parameters of the contractual relationship. For instance, he or she should establish a set of time and length for their first few sessions. One-hour sessions are typical.

The therapist should also request that each individual attends the first several sessions in order that the therapist can observe how the couple interact, to introduce both to the counseling process, and to gather information from each person. Later sessions can be joint or individual. The general idea, again, is that the therapist sets the initial limits (without being dogmatic) for their relationship. As a function of their pathology, individuals may attempt to manipulate the therapist in these early stages. By being firm and consistent, the therapist can begin, very early, to restructure dysfunctional interactional behaviors. By vacillating, the therapist would allow an individual to control his or her behavior. This would open the door for resistance to interventions at a later date.

The second task is to make contact with each person and to elicit help and information from the client. The therapist wants to communicate both his or her concern for the clients and a willingness to accept it no matter what develops in their relationship. The classic concepts of therapeutic rapport are relevant at this point. Trust,

acceptance, confidentiality, and unconditional positive regard are attitudes that the therapist communicates to each person to build rapport. Each individual should be led to feel both that what he or she says is important and that he or she is important to the success of the relationship.

The third critical task of the therapist is to model healthy communication–perception processes. The therapist must be clear and specific in interactions with the couple. And he or she must insist that clients behave in this way also. Therapists should make sure that they understand what is being communicated by clarifying clients' statements and feelings on a regular basis. At the same time, the therapist can teach family members to display good perceptive behaviors by asking them to clarify others' statements and to give specific feedback to one another. Tracking, normalizing, and punctuating are particularly helpful techniques at this point and throughout the process.

A fourth critical task involves explaining the workings of a systemic approach to the couple. Just as beginning therapists have to learn to think about the system (and not just the individual), so does the couple need to make this systemic shift. A basic principle of systems applies here. A change in any part of the system affects all other parts of the system. A simple child's mobile is an excellent tool to use for demonstration to the couple. Having a mobile hanging in the therapy office is recommended to every IFT therapist. This explanation takes no more than several minutes, and it can be repeated occasionally throughout the process. Once the clients begin thinking systemically, therapeutic interventions are more easily accepted and change accelerates in the system.

The four tasks outlined above are considered to be critical for a productive therapeutic relationship. These tasks are somewhat antagonistic to each other in that the therapist is asked to behave in several potentially conflicting ways simultaneously. He or she is asked to be controlling, yet accepting, and to be individually oriented, yet concerned about the whole group. In one sense, these may be tasks that the clients need to accomplish. By demonstrating such a range of ways in which to be functional, the therapist can set the stage for later change. In other words, these tasks are critical to the therapist to manage future sessions successfully. But they are also important to the clients because they may be behaviors that will be required of them to function more effectively in the future.

***Observation and assessment.*** The second stage in the process involves an analysis of the couple and each individual. The

therapist first attempts to identify and isolate specific problems that have propelled the couple into therapy. These will be translated into short-term goals for the immediate future. Temporary resolution of the most pressing immediate concerns can free the couple to deal with the more pervasive, general dysfunction that is causing them pain. The long-term goals relate specifically to this general dysfunction.

The bases for observation and assessment in IFT are the five specific concepts discussed earlier in the chapter. Using these concepts, the therapist develops a diagnostic picture of individuals and the couple unit. He or she can observe present interactions and evaluate descriptions of past functioning on the basis of this framework. An important element of this picture is the couple's definition of the problems. How do the clients evaluate the past and present situations? How do they propose to resolve their difficulties?

The major portion of this stage can be accomplished within the first two sessions. The primary dynamics should be observable in this period of time. Notes may be taken during these early sessions to develop a printed assessment card. The five concepts are used to organize the notes. Between the second and third sessions, the assessment card is developed by the therapist listing five or six major goals of change for individuals and the couple. The general concept of the observation and assessment stage may be summarized by the following:

- It provides a diagnostic picture of individuals and of the couple.
- It establishes short-term and long-term goals.
- It determines present and future interventions.
- It is shared with the couple in written form and discussed by all members.
- It is accepted or modified by all persons in the session.
- It is flexible enough to incorporate new data as therapy progresses.
- It is subject to change and reevaluation.
- It is the start of the intervention process.

***Intervention.*** In the third stage, the assessment card is shared with the couple and contains the therapist's suggestions for therapeutic goals in rank order of importance. A sample of an assessment card is given in the Brief Case Example section below. During this intervention stage, the couple is given time to read and digest the information and is then asked to react to the assessment and to the plans for future therapeutic contact. Mutual goals are set at this

time. The remaining work in therapy is based on the therapist's overall evaluation and interaction with the couple regarding the assessment card. Thus, all therapeutic interventions will be guided by the interactions in the session. This is not to say that the therapeutic plan is unchangeable. Continual reevaluation of the working hypothesis is prudent and advisable. If changes are necessary, they should be discussed with the couple and instituted immediately. The presentation of the assessment card is the beginning of the intervention process. Thus, Stage 2 flows naturally into Stage 3. The discussion of the assessment card and the beginning interventions usually occur in the third and fourth sessions.

On the basis of the diagnostic picture presented on the assessment card, the therapist begins to actively intervene in the system. Theoretically, intervention cannot occur until the evaluation has been completed. However, in reality, the therapist begins the change process from the first session. The behaviors that the therapist uses to structure a couple and to assess dynamics are intervention strategies. His or her mere presence, as a professional, causes individuals to interact in a different way. This difference in patterns can be pointed out, thus creating change outside of the session. In other words, any contact that the therapist has with the clients is potentially an intervention.

***Change maintenance.*** The primary task of the fourth stage of therapy is to reinforce new behaviors and patterns of interaction. The therapist will continue to use his or her intervention strategies. These will probably be used in a less active, less directive manner. The couple is now taking more responsibility for each other's present and future behavior. The therapist will increase the time between sessions, as the therapist gradually removes himself or herself from a central position in the system. Two- and 3-week intervals between sessions are common in this fourth stage. The therapist can now help the couple to generalize the new insights and behaviors to all aspects of their lives. They no longer focus all of their energy on coping with present conflicts. A satisfying problem-solving process for the present and future has emerged. The couple is actively involved in planning for, and is more optimistic about, the future. However, the therapist must guard against moving too quickly through this fourth stage. Premature withdrawal of the therapist's influential position in the unit can trigger the homeostatic mechanism. Without the continued input and reinforcement of the therapist, a couple can revert to old behavior patterns. Progressive movement through this fourth stage will decrease the

likelihood of relapse. Stage 4 usually involves the fifth through the eighth session.

***Review and termination.*** Termination, the final stage, is indicated when a couple displays the following behaviors:

- Present-day conflicts are resolved in a mutually satisfying manner.
- Partners express optimism about future plans.
- The couple sets realistic long-term goals for the unit and each other.
- Each member has internalized the new behaviors, attitudes, and feelings.

When the therapist observes these behaviors occurring on a regular basis, termination can be instituted. The therapist should first review the couple's entire therapy process and specifically reinforce the new behaviors and interactional patterns. The therapist should then check each individual's feelings and attitudes toward the changes that have occurred. Has each member personalized and internalized the changes? Next, the therapist should discuss the future goals of the unit and of each member.

The final task of the therapist is to present written and verbal feedback to the couple concerning the therapist's perception of the therapeutic process. This would include the initial presenting problem, assessment of the unit, and individual members' goals; review of new individual and couple behaviors; and an evaluation of the couple's present functioning. It is suggested that this feedback be in written as well as verbal form, using the original assessment card as a basis, so that the couple can review the therapist's evaluation at any time in the future. It is not unusual for couples to review the feedback card at regular intervals. In this way, it provides continued reinforcement of therapy, long after formal counseling has ended. Four-week intervals between sessions in this last stage are the norm. Termination often occurs in Sessions 9 and 10.

The stages of the therapeutic process are theoretical. They are part of the conceptual framework that is used both to organize the therapy process and to remediate dysfunctional families. The process itself is intensive and short term. Most couples complete the five stages in 10 to 12 sessions spread over 4 to 5 months. Some clients can reach termination in as few as 5 sessions over 2 to 3 months. Others require more extensive reorientation and may be in therapy for a longer period of time. Regardless of the duration, the

theoretical process is essentially the same. Successful therapy, in other words, always follows the progression from structuring to termination with all the drama, pain, excitement, and pleasure of the intervening stages.

### *Techniques*

Any well-accepted technique from any of the major models of family therapy may be used in therapy. A sound rationale is the guiding principle for the selection of any therapeutic maneuver. The following are examples of common intervention strategies.

1. Apply basic skills, including tracking, punctuation, normalizing, and deconstruction, in all therapeutic situations.
2. Present and discuss the assessment card at the beginning of the intervention stage. Each goal on the card is discussed with the clients, and examples from previous sessions are used to illustrate each point.
3. Discuss and enact specific problem situations. Through discussion of recent examples of conflict situations, the therapist can assist the clients to generate alternative solutions.
4. Use confrontation techniques to help people communicate more accurately and effectively with one another.
5. Use communication checks to ensure accurate perception on the part of all members. Assumptions and inaccurate perceptions should be immediately identified and corrected.
6. Work out definite roles and expectations for each person. Negotiation may be necessary to achieve mutually satisfying positions. Consequences may need to be established for the noncompletion of expectations.
7. Set general or specific rules that will govern clients' daily lives. They decide how they want to organize their daily living patterns.
8. Encourage the couple to practice new behaviors at home to supplement the in-session work. Meetings can eventually take the place of therapy.

### *Role of the Therapist*

The therapist is a professional with specific skills who is employed as a consultant to the couple. The relationship is never power-related or adversarial. In a sense, it is a businesslike arrangement that happens to involve intensely personal ideas, feelings, and be-

haviors. The therapist controls the sessions by structuring and instilling confidence and optimism regarding the potential for change. The couple experiences order and stability in the sessions. The therapist's behavior provides a role model for individuals to emulate in the session. For example, by modeling healthy communication–perception processes, the therapist teaches the couple how to engage in clear and specific interactions. The therapist observes and assesses each individual to provide feedback and to actively intervene in troublesome patterns.

## Evaluation of the Model

The efficacy of IFT has been tested primarily on the basis of the experiences of the therapists and the reports of change by the couples and families over a 25-year period. In the past 15 years, a rating scale comparing the goals on the assessment card and the final evaluation of the therapist and clients has been used to assess the degree of change on major variables. A 5-point scale (ranging from 1 = *no goals attained* to 5 = *all goals attained*) is completed by the therapist after the final session. Ratings of couples/families seen in the past decade range from 2 to 5 with a mean rating of 4.2.

A study by Walsh and Wood (1983) compared the Dynamics of Family Life Scale, an instrument based on the IFT model, with several other family measurement scales. Twenty-six families who were in treatment because of difficulty with an adolescent member were participants of the study. With the use of statistical tests of significance, the instrument was found to be useful in identifying the degree of dysfunction in the family unit. The findings were consistent with independent assessments of the therapists. A high degree of consistency was observed between the variables identified in this study and in two major studies of similar instruments (Faunce & Riskin, 1970; Lewis, Beavers, Gossett, & Austin, 1976). The following correspondences were found:

1. Functional family units typically had a warm and expressive feeling tone, and they were generally more openly expressive and empathic.
2. Low levels of conflict characterized healthier families.
3. Clear parental coalitions were prevalent in healthy families, and subsystem composition in general was highly related to degree of dysfunction.

4. Healthier units tended to be clear in their expressions of feelings and thoughts.
5. The relationship between distorted perception and dysfunction was found to be stronger than the relationship between distorted communication and dysfunction.

## Brief Case Example

Frank (age 41) and Helen (age 39) have been married for 20 years and have three teenage sons. Frank works as a welder, and Helen is a school aide. They were referred to therapy by the local high school because of truancy and failure issues with their middle son. During the initial phone call, Helen told the therapist that she and her husband were also experiencing significant conflicts in their relationship. She wished to enter counseling with her husband and discuss these conflicts, if she could get her husband to attend. She felt they could look at their son's problems at a later date. The therapist agreed, and a session was scheduled for the following week.

Helen and Frank appeared at the appointed time for their session. Frank expressed his nervousness and doubts about the success of this venture but was willing to talk about his son's difficulties. Helen had not told him about her own agenda of changing their relationship. As Frank became more comfortable, he talked at length about their difficulties with their 16-year-old son. He also said how stressful this had been on their marriage, but paradoxically he felt that the troubles had brought them closer together. He now would like to spend more time with Helen, but he felt that her criticism of him often drove him away. Helen listened closely and waited her turn. She took advantage of Frank's discussion of their relationship to express her real agenda. She said that their problems were "buried" and also that Frank focuses his attention elsewhere. She was particularly disturbed by the time he spent on the Internet with a lady friend and high monthly charges on their cell phone. She said that she could no longer trust him. Their son's difficulties were barely mentioned throughout the session. Throughout the session, the therapist performed the structuring tasks of Stage 1 of the process and the observation and assessment tasks of Stage 2. It is common in Session 1 to let the couple lead the conversation, with the therapist using questions for clarification or expansion of a topic. Before the next session, the therapist will assess the data from Session 1 and structure Session 2 to complete the assessment card. It was determined that considerable information was obtained on com-

munication and perception, as well as some data on family structure and expectations.

In the second session, the following week, the therapist gathered structural data on Frank and Helen's families of origin, as well as how their experiences shaped more specific expectations and consequences for each other. Both were observed to be uncomfortable discussing their past and present expectations, and Helen would often giggle before she spoke. At the end of the session, they were asked as a homework assignment to identify five expectations each had for the other. They were also told to expect the assessment card the following week. Before the next session, the assessment card (shown below) was developed on the basis of the data from the previous two sessions.

**Family Assessment Card**

The assessment of your strengths and weaknesses is based on observation and clinical evaluation by your therapist. The assessment will provide important information for you. A commitment by each member to work on mutually agreed upon goals both in the sessions and at home between sessions will maximize the value of this assessment. Work on each of the goals will help you and your partner to function more effectively and help your family to change and grow.

**Goals**

1. Helen and Frank need to continue to build on their communication skills and improve their listening skills.
   a. Maintain eye contact when speaking to each other.
   b. Check to see if you fully understand what the other person is expressing.
   c. Practice clear and direct statements by voicing your own needs.

2. Make time to talk to each other about your relationship without distractions.

3. Helen and Frank need to rebuild trust in their relationship.
   a. Be honest and clear about your expectations for each other.
   b. Do what you say you are going to do.
   c. Change behaviors in areas where trust has been broken, for example, secret phone calls and hidden phone bills.


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4. Helen and Frank need to continue to work together as a parental team.

5. Helen and Frank need to be consistent with parenting and disciplining of their children.
   a. Develop mutual and consistent expectations for the children.
   b. Develop mutual and consistent consequences for the children.

The listing of five goals with some subareas is typical for an assessment card. As can be noted, Frank and Helen's card covered most of the tenets in the model. Goal 1 focuses on communication and perception, Goals 2 and 4 discuss structural issues, and Goals 3 and 5 involve role responsibility.

Frank and Helen seemed excited to receive the card and invested in the process of review in the third session. Both were particularly pleased with Goal 2, spending time together. As it is, they currently spend 95% of their time together talking about the boys. The therapist normalized this situation. Each had a difficult time deconstructing trust in Goal 3 and identifying how they could change their behaviors. Relating to Goal 5, Frank said he needed help learning how to follow through with discipline for the boys. Helen, discussing Goal 3, said she would like Frank to do more nice things for her. For homework, they were asked to focus on Goals 1 and 2.

The following five sessions were spent continuing to intervene with the five goals, and then moving into the change maintenance phase. Since much work had occurred on Goals 1 and 2 with the homework assignments, both goals were reviewed and then the majority of Session 4 dealt with their struggle with Goal 3, trust. The speaker–listener technique was introduced in Session 5, and work continued on the first three goals. Frank was sick for Session 6, so Helen worked alone on the speaker–listener technique with the therapist. She also had time to discuss her own positive feelings about changes in the system and her continuing struggles with the boys. In Session 7, the blocks technique (Walsh & Furios, in press) was introduced to them. This is a structural intervention that I developed to demonstrate subunits and boundaries in a system. Children's alphabet blocks are used to represent each member of the system, and paper or other handy objects represent rigid, clear, or diffuse boundaries. Frank and Helen particularly liked the visual and kinesthetic aspects of this technique, and they readily began

moving the blocks to represent different situations dealing with Goals 4 and 5. This continued into Session 8, with the addition of the rearrangement of seating positions to reenact specific situations and mimic the block arrangements.

Sessions 6 through 9 occurred at 3-week intervals, which is typical for IFT. Homework was assigned and mostly completed between each session. At the 9th session, the assessment card was reviewed, and Frank and Helen were feeling positive about their work on the five goals. It was determined that the next session in 4 weeks would be their last. In the 10th session, the card was again reviewed and continued growth was discussed. The 10-session process ended in 4 months.

## Summary

The stages of the therapeutic process are theoretical. They are part of the conceptual framework that is used both to organize the therapy process and to remediate dysfunctional families. The process itself is intensive and short term. Most families complete the five stages in 10 sessions spread over 4 to 5 months. Some families can reach termination in as few as 5 sessions over 2 to 3 months. Others require more extensive reorientation and may be in therapy for 9 months to a year. Regardless of the duration, the theoretical process is essentially the same. Successful therapy, in other words, always follows the progression from structuring to termination with all the drama, pain, excitement, and pleasure of the intervening stages.

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# 3

# Integrative Couple Therapy: Beyond Theory and Practice

Robert L. Smith, PhD

> Working from an integrative perspective is hard work. First, it is difficult to define and then inform others what you actually do; then there is so much that needs to be integrated, there is the therapist, clients (couple), the relationship, systems specifics, theory/techniques, and everything else that influences and interacts with individuals and couples, it is unending.
>
> —Robert L. Smith

As stated earlier in the book, it is becoming more apparent that practitioners who work with individuals and couples are less likely to provide therapy from a preconceived traditional model, approach, or theory. To offer the most effective psychotherapeutic services to clients (i.e., couples and individuals), modern-day therapists need to consider a wide range of variables that affect the change process. These variables go far beyond a particular theory or approach.

Lebow (1997) described the movement toward integration in therapy as a quiet revolution taking place across the United States. Although seemingly quiet, the literature has included several articles and texts discussing integration in therapy (Breunlin, Schwartz, & Mac Kune-Karrer, 1992; Duncan & Parks, 1988; Feldman, 1985;

Jacobson & Christensen, 1996; Kaslow, 1981; Pinsof, 1995). As compared with the 1960s and 1970s, currently, only a modest number of therapists believe one method or approach to therapy is sufficient to meet the needs of a wide range of individual and couple issues. If there are practitioners with this belief, they are more likely disciples of some of the traditional theorists who were founders of well-conceived approaches advocated at a particular time in the history of psychology and counseling. However, many therapists, including the founders of individual, couple, and family approaches, have understood the necessity of using a variety of methods and concepts throughout the course of therapy. It now seems essential, if not ethically responsible, that practitioners integrate the best practices available when working with clients. Combining theories and techniques is one aspect of integrative therapy. This aspect of integration is considered to be the first level of integration, as discussed in chapter 1 (see also Sperry, 2000).

Integration as discussed in this chapter should not be confused with an eclectic approach to therapy. Here *integrative therapy* is defined as a framework for therapy and change outlined by the therapist that considers the following:

1. The therapist himself or herself as a person (gender, values, beliefs, experiences, knowledge-base, etc.) and the client or clients (their personal characteristics and readiness level).
2. The relationship between the therapist and client.
3. The client or couple system (developmental stage and other characteristics).
4. The use of known theories, techniques, and change processes.
5. Mega-systems interacting with clients (culture, finances, work, spirituality, legal, etc.).

An eclectic approach is a case-based approach that uses different concepts or techniques to affect change without concern for a preconceived framework of therapy or systems that are external to the couple unit. Traditionally, an eclectic approach has concentrated on what happens within the therapy room with the therapist using techniques or practices that are considered congruent with the client's needs.

## An Integrative Model

More specifically, an integrative model includes the integration of constructs known and supported by research as being essen-

tial for change. Included within this model are relationship characteristics and necessary ingredients for change that research has demonstrated to be of major significance despite therapeutic orientation or technique used (Miller, Duncan, & Hubble, 1997). These have often been referred to as core conditions or core dimensions. Mega-systems, or constructs affecting the client throughout life outside of therapy, are important variables considered in this integrative approach. Mega-systems and external variables include the clients' milieu, family, extended family, health, work/career, culture, religion and spiritual influences, and all circumstances or situational events interacting with the client outside of therapy. Miller et al. (1997) referred to these as extratherapeutic factors. Lambert (1992) and Lambert and Bergin (1994) estimated that as much as 40% of the variance in psychotherapy outcome can be attributed to these extratherapeutic factors. Personal characteristics of the therapist are included as a part of this integrative model of therapy. Although personal characteristics of the therapist have been viewed as important to the therapeutic process and outcome, there has been minimal discussion or monitoring of these characteristics before or during the course of therapy. Yet, the therapist's beliefs, values, experiences, and training serve as precursors to theory selection, techniques used, and concepts emphasized during therapy.

When counseling with couples, one needs to consider data about the couple system itself in one's integrative approach. This includes the developmental stage of the couple's relationship, rules, roles, power structure, boundaries, traditions, and culture. Finally, considered in most integrative approaches discussed in the literature is theory, or the combining and interweaving of several approaches within the therapeutic process. Most integrative theories combine three or more major theories that serve as the working framework for therapy.

An integrative model that goes beyond theory and techniques is displayed in Figure 3.1. At its core are the individuals within the therapy room and all that they bring with them. The therapist's personal characteristics, values, beliefs, and experiences determine the course and eventual effectiveness of therapy. The outer circles of this model become larger and include comprehensive systems that affect the therapeutic process from beginning to end. Although separated by circles in this pictorial, elements of this integrative model should be viewed as constantly interacting with each other or as being truly integrated with one another.

**FIGURE 3.1**
**An Integrative Model: Beyond Theory and Technique**

Mega-systems: culture, work/career, social, peer, judicial/legal
School, other, other, other, other

Theory and Techniques

Individual and Couple Systems

The Relationship

The Person as the Therapist
Client/Couple Characteristics

The Relationship

Individual and Couple Systems

Theory and Techniques

Mega-systems: culture, work/career, social, peer, judicial/legal
School, other, other, other, other

## Practicing Integrative Framework

The practicing integrative framework is "what the therapist does" during therapy. When one asks the question, "What is your theoretical orientation?" the reference is to what the therapist does while meeting with clients and what theory the therapist follows. If one practices cognitive–behavioral therapy, the answer would be, "My theoretical orientation is cognitive–behavioral." The integrative therapist would state, "My theoretical orientation is integrative therapy." Most people, on hearing this response, would be thinking what is described in this text as Sperry's Level 1 integration (see chapter 1). They would be assuming that the therapist's practice includes the combination of several theories and techniques when working with clients. This is one's practicing integrative framework and is one component of the integrative model.

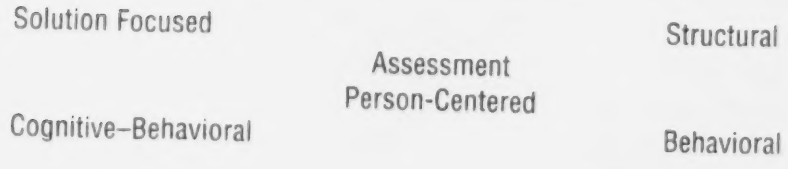
The practicing integrative framework includes solution-focused therapy, structural therapy, cognitive–behavioral therapy, and behavioral therapy. Therapeutic approaches within this practicing integrative framework are not used in a linear or cookbook manner. Client characteristics, severity of the presenting problem, and readiness for change are some of the variables determining how and when different approaches are used. A person-centered disposition serves as an overlay for all therapy within this approach. By being person-centered, the integrative therapist receives direction for therapy, including what concepts to examine and what approaches to use with clients. Because of its importance, the relationship consisting of a client-centered disposition is included as a section of its own within the integrative model.

The practicing integrative framework, as expressed here, considers the importance of past, present, and future as related to the individual and the couple unit itself. Thoughts, feelings, and behaviors are also important concepts emphasized over the course of therapy. It is believed that all of these modalities need to be addressed during therapy.

Figure 3.2 provides a pictorial of the practicing integrative framework. The concepts covered and theories used should be viewed as fluid. It is recommended that therapists have sufficient knowledge of, and experience with, any approach to therapy they use as a part of their practicing integrative framework.

The practicing integrative framework includes concepts found in several theories that can be seen as basically good practice methods and as theoryless. The practicing integrative framework considers assessment to be an integral part of one's work with individuals and couples before, during, and after therapy. Assessment is therefore centered in Figure 3.2. Person-centered therapy also holds a central position because of research findings identifying the relationship as critical to therapeutic outcome, despite approach or techniques used by the therapist. Additionally, it should be noted

**FIGURE 3.2**
**Practicing Integrative Framework**



that an examination of the past, present, and future is part of the practice, as well as working with the three modalities of feelings, cognitions, and behavior. The therapist is considered the embryonic facilitator of change, and as such uses her or his professional skill and experiences to determine what areas should be emphasized and what concepts from the different approaches should be integrated during the course of therapy. Although the above concepts and theoretical orientations have been sufficient in most cases, it is believed that a practicing integrative framework should be adaptable and left open to other concepts and practices that can effectively meet the client's needs. Therefore, Figure 3.2 is not completely enclosed. Attempts by students and many practicing therapists to declare one approach to therapy and religiously follow a set theory has too often boxed in the therapist while limiting his or her vision and ability to most effectively solve a wide array of client problems. An example of opening the door to additional concepts and approaches might be if a client or family system is stuck and psychodynamic issues and trauma are evident. The therapist may need to meet with family members both alone and as a couple unit. If the therapist has skills in these areas, psychoanalysis and eye movement desensitization and reprocessing (EMDR) would be the modalities of choice. If trauma were present, EMDR would be recommended as an option when considering outcome studies that have recently supported its effectiveness with trauma.

## Assessment and Integrative Therapy

As with any integrative model, assessment is of paramount importance (Kaslow, 1981). It is inconceivable that an integrative model would be successful without effective and continuous assessment of numerous systems that affect therapeutic outcome: individual systems (therapist and clients), couple systems, and multilayered systems interacting with clients. Assessment should also include a continued review of the relationship because of its recognized importance to therapeutic outcome.

A number of measures have been developed to assess couple systems. Typically, these assessment measures have focused on preconceived beliefs about healthy relationship constructs or around a particular approach or theory. Many of these measures can and have been used by integrative therapists. Some measures provide information about a specific level of integration, and others examine multiple levels of an integrative model. Lazarus (1989) was one

of the first to develop and use an assessment measure that integrated a broad spectrum of questions providing multilevel information about clients. My suggested integrative model includes several concepts found in the Multimodel Life Assessment Questionnaire.

Integrative therapy with couples includes a systemic assessment of individuals and the couple unit. It is important to gain an understanding of how the couple functions as a system. The assessment process by therapists following a singular approach to therapy should correlate to their specific theory. For example, therapists working from a structural perspective in therapy would ask questions about hierarchy, boundaries, rules, and couple roles. A solution-focused therapist would ask different questions that may evolve around what has worked in the past, how it worked, what the couple did to make things work, and how resources could be garnered to move forward again. A psychodynamic therapist would focus more on the role of assessing intrapsychic forces operating within and affecting the couple system. An understanding of anxiety and internal sources of discomfort would warrant review.

Assessing the couple system dynamics from an integrative perspective requires that the therapist have a clearly defined integrative framework identifying the actual practice of therapy. Only by having this framework spelled out will the therapist obtain directives in developing his or her assessment questions of the couple system itself.

Therefore, information about the couple includes questions related to past functioning (as a couple and as individuals), present functioning, and goals for the future. Additional questions are asked about cognitions, affect (feelings), and behavior. Individuals and couples are queried through an integrative intake questionnaire (see Table 3.1). Further information about past and current functioning is obtained from a genogram. Other questions asked in session, or through other assessment measures, correlate with the practicing integrative framework.

**TABLE 3.1**
**Integrative Intake Questionnaire**

Name _____

Address _____

Telephone (day) _____ (evening) _____

Age _____ Sex _____ Occupation _____

Relationship status: ❑ Married ❑ Single

Living with someone_____ Children:____ Ages ____ ____ ____ ____ ____ ____

By whom were you or your family referred?

State in your own words the problem or problems (why are you here)

When did the problem(s) begin? _____

Rate the severity of the problem _____

Extremely Severe Not a Problem

1 2 3 4 5 6 7 8 9 10

What will it be like when the problems are solved? (e.g., what will you and other family members be doing)

How are decisions made in your family?

Describe some family rules:

When you think of yourself, what thoughts come to mind?

When you think of your family, what thoughts come to mind?

Are there specific behaviors or actions you would like to change? (describe)

What behaviors would you like to keep or increase?

Are there feelings you would like to experience more often?

Are there feelings you would like to experience less often?

Describe your relationship with your spouse or partner

Describe your relationship with your children

Discuss any physical health concerns of yours and/or family members

List medications that you have taken in the past and those you might be now taking

Identify the use of any substances taken by you or taken by any family members

Have you, or anyone in your family attempted suicide?

State your goals for therapy

How long do you think therapy will take?

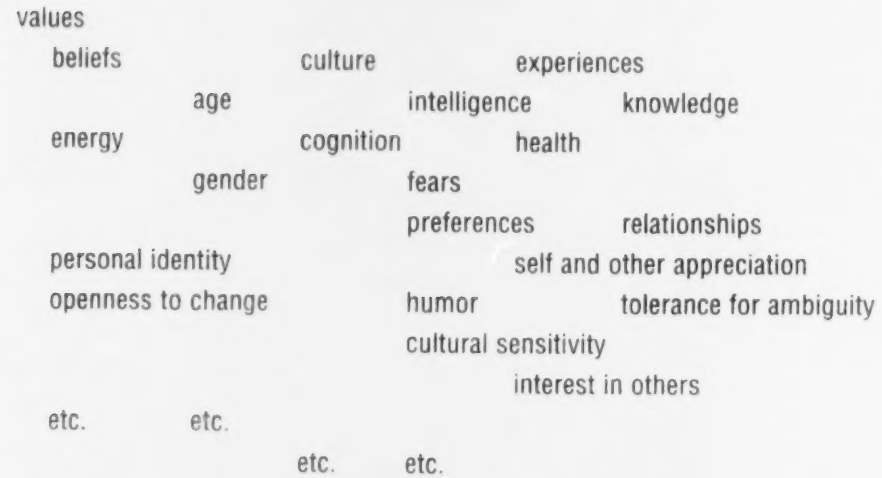
## At the Center: The Person as the Therapist

At the center of this integrative model sits a number of individuals who find themselves in a therapy room. Of immediate significance is the therapist, or the person who is conducting therapy with the individual or couple system. In truth, at that time and at that moment, most of what evolves during therapy can be attributed to the person as the therapist. The person as the therapist plays an embryonic role concerning all that happens (in the therapy room) from here on during the course of therapy, including the time of sessions, length of sessions, therapeutic areas of inquiry, techniques used, and theories followed. All that is present within the therapist—his or her values, beliefs, experiences, intelligence, knowledge, training, traumas, relationships, energy, health (physical and mental), gender, cognitions, fears, and preferences—are integrated into therapy, forever inseparable. How and to what degree they affect and account for therapeutic outcome is not only difficult but also impossible to measure. Yet, the person as the therapist is important. Training programs and universities have recognized this, as

they continue to emphasize self-discovery by the student before allowing one to work with others. It is for this reason that when therapy is viewed from an integrative perspective, consideration must be given to the importance of the person as the therapist. Whether this is at the center of therapy is debatable. Whether the person as the therapist is important in therapy is not considered debatable.

Figure 3.3 provides an enlarged picture designating the inner circle of the integrative model. Within this inner circle is the therapist. Integrated within the therapist are thoughts, feelings, behaviors, and multiple sets of personal characteristics and experiences. Examples of these are included within Figure 3.3. The list, however, is unending, because all experiences, thoughts, and behaviors are indelibly retained by people, with some having more influence than others. The recipient of these interacting variables is the individual or the couple. In addition to this personal list is another set of therapist characteristics considered to be important for those providing counseling or therapeutic services. This list (Corey, 1996b) includes such traits as one's personal identity, appreciation of self and others, openness to change, humor, tolerance for ambiguity, cultural sensitivity, and a basic interest in others. These characteristics, seen to affect the course of therapy, often evolve from the person's values and experiences. Although not intended to be viewed as a fixed model of perfection for counselors or therapists, Corey (1996a, 1996b) saw these characteristics as significant when helping individuals

**FIGURE 3.3**
**The Person as the Therapist**



become therapeutic persons. In short, they affect the therapeutic process.

## Client (Couple) Characteristics

The other dynamic within the milieu of therapy is the individual or couple system. Characteristics of this system, including individual personal traits, also affect the course of therapy. The readiness for therapy by each individual making up the couple system, and the system itself, are variables determining therapeutic outcome. When there is a couple in the counseling office, one becomes involved in examining multiple systems: individual, couple, extended family, and numerous interacting mega-systems. Information about clients (couples) can be obtained through the therapist's discovery process involving intake questionnaires, genograms, observations, and in-session questions. The importance of assessment is magnified when one is using an integrative approach, as compared with a counselor operating from one theoretical stance. Ideally, an examination of each client would include an assessment similar to that completed by the individual therapist. Personal information about each individual's values, beliefs, experiences, and so on will assist the therapist when working with individuals and couples. A complete client assessment would reveal information for each member of the couple system similar to that found in Figure 3.3.

## The Relationship

"Without question, a positive therapeutic relationship is an important requirement for a successful outcome in psychotherapy, and this applies to all forms of psychotherapy" (Garfield, 1989, p. 25). Garfield made this claim because of the convincing body of evidence designating the importance of the relationship (most often identified as the facilitative conditions, core dimensions, core conditions, or essential ingredients for change) in therapy outcome. The concepts of essential ingredients for change in therapy and core conditions date to the early work of Rogers (1957), whose necessary or essential ingredients for change included the concepts of empathy, respect, and genuineness. Subsequently, these concepts expanded and became known as the core conditions. These conditions and their importance in therapy have been closely reviewed, quantified, and researched (Carkhuff & Berenson, 1967; Ivey, 1988;

Lambert, 1992; Patterson, 1974; Truax & Carkhuff, 1967). Studies have clearly indicated not only the importance of these core conditions but also that their presence takes precedence over any theory or technique used by therapists with individuals and couples. Lambert (1992) concluded that at least 30% of the variance in psychotherapy outcome was attributable to the relationship factor.

Because of its significance, the relationship between the therapist and client (or clients) is considered a major part of this integrative model. Therapists operating from any model cannot ignore the critical nature of this factor. Most training centers and universities preparing mental health specialists have emphasized the relationship as a key ingredient when working with individuals and couples. A number of programs specifically emphasize the core conditions and directly attempt to increase levels of empathy, genuineness, and warmth of students when working with clients.

The relationship discussed in terms of the core conditions is found throughout the literature (Capuzzi & Gross, 1999; Combs, 1986; Corey, 1996b; Egan, 1994; Gladding, 1996; Ivey, 1988). These conditions include the following: empathy, genuineness, respect, congruence, positive regard, concreteness, warmth, and immediacy. Most major counseling and psychotherapy texts provide definitions of these important elements that affect the course of therapy and the therapeutic outcome. It would be advantageous for therapists to periodically review their own levels of empathy and other core conditions, either through self-examination or by having colleagues directly observe their work or critique their videotapes.

If practicing counselors and therapists are able to integrate the core conditions within their own style when working with clients, therapy effectiveness will increase significantly. The person-centered therapist uses the core conditions as the basis of therapy. It is recommended that all therapists, including those designating themselves as integrative, stress high-functioning core condition levels when working with clients.

## The Couple System

When using an integrative model, therapists must consider a number of variables associated with the couple system. The integrative model, discussed in this chapter, examines individual systems, including the therapist and client (or clients). The interaction between these individual systems (the relationship between therapist and clients) has also been reviewed. The clients, although con-

sidered to be subsystems within the couple system, were viewed from an individual perspective, as was the therapist. It is time to view the couple system from a unit perspective by examining their interpersonal dynamic.

As part of an integrative model, the therapist assesses the couple system from many perspectives. Any data gathered about the couple should correlate with the therapist's practicing integrative framework. In addition to these data, other information about the couple should be sought, including the developmental stage of the couple system. Whether practicing from an integrative perspective or from an individual theory, all data gathered about the couple system should relate to one's practicing framework or theory. For example, a structural therapist would assess the boundaries, coalitions, and hierarchy of a couple system, whereas an intergenerational therapist would focus on beliefs, conflicts, and losses transferred over generations. Although the data gathering and corresponding theoretical models help therapists organize their thinking, they are limiting in practice. Holding to one theory and gathering data specific only to that theory eventually limit one's effectiveness as therapists work with a wide range of issues (Hanna & Brown, 1999).

The practicing integrative framework presented in Figure 3.2 included several theoretical models and therapeutic concepts. This framework consists of person-centered therapy, solution-focused therapy, cognitive–behavioral therapy, structural therapy, and behavioral therapy. Table 3.1, the Integrative Intake Questionnaire, asked questions related to each of the theories. In addition to these data, other couple system information is a part of the integrative model. The model is open-ended with only the limitation of time affecting the data-gathering process. Table 3.2, The Couple Review, provides information obtained from the couple through a questionnaire. These questions are often asked in session. The first area of inquiry involves the functioning of the couple system over three generations. The genogram is customized to the practicing integrative framework and is often constructed in session with the therapist's help. Areas emphasized when using the genogram are behavior patterns used over generations (behavioral), attempted solutions to problems and what has worked (solution-focused), the organization of at least two systems related to hierarchy, rules, and roles (structural), as well as communication patterns (effective communication, person-centered). Other areas of assessment concerning the couple include gender-related issues, culture-related topics, and developmental stage. Questions asked in these areas are included in Table 3.2.

## TABLE 3.2
## The Couple Review

1. The Genogram
   Please complete a genogram that includes three generations. (The genogram should include family members; their relationship to each other; ages; dates of marriage, death, divorce, and adoption; and places of residence. Women are symbolized by circles, and men by squares. Horizontal lines are used for couples and dates. Marriages are noted by solid lines, and common-law unions are noted by dotted lines. Vertical lines extending down from couple lines connect parents and children.)

2. Gender Factors
   a. Discuss the roles around men and women in your current family.

   b. Discuss the roles around women and men in the family in which you grew up.

   c. Are there certain traditions in your family that are more closely related to either women or men?

   d. How does your family address the differences between females and males in our society?

3. Cultural Factors
   a. How does your cultural/religious/racial heritage make your family different from other families you know?

   b. How might an outsider view your family from a cultural/religious/racial perspective?

   c. What are the values that your family identifies as being important parts of your heritage?

4. Developmental Stage Factors
   a. What stage is the family at now? What major life transitions has the family lived through?

   b. Are there any indications that previous life stages need to be discussed?

   c. What is the next stage of development for this family?

## The Integration of Theory and Techniques

Forty years of sophisticated outcome research has not found any one theory, model, method, or package of techniques to be reliably better than any other (Miller et al., 1997). The authors of *Escape From Babel* (Miller et al., 1997) came to this conclusion as a result of reviews of the literature on outcome research in the field (Lambert, 1992; Lambert & Bergin, 1994). They estimated that, at best, theory or approach by the therapist may account for 15% of the outcome in therapy. They considered the data to be clear on this issue, concluding that the model of therapy does not make much difference in outcome of therapy. It is with some chagrin that those teaching and practicing in the field question why so much time is spent in training programs emphasizing theory, insisting that students have their theory well constructed and articulated before seeing clients, when it is clear that a number of other factors are significantly more relevant when it comes to therapeutic outcome.

Despite current findings about factors influencing therapeutic outcome, no one is advocating that theory be ignored in the practice of therapy. Instead the research findings serve more as a testimonial that one should not rely on a single theory or approach. The evidence seems clear that clients will be served best when therapists integrate several theories in their work. No one particular theory is seen as applicable to all clients, who present myriad problems and issues.

The practicing integrative framework, displayed in Table 3.3, interweaves four approaches to individual and couple therapy. The person-centered approach serves as a constant within each theory utilized. The four theories interwoven are solution-focused therapy, cognitive–behavioral therapy, structural therapy, and behavioral therapy. These approaches are considered effective with most presenting problems by individual and couple systems. The approaches are not used in a linear manner or a particular order. For example, a couple that is not in crisis and has in the recent past functioned at a high level could immediately benefit from a solution-focused approach. However, if there have been long-term problems within the couple system and they see the therapist while in a major dispute or crisis, a solution-focused therapy would not be appropriate. The application of person-centered principles would be important along with support, understanding, and clarification by the therapist. If abusive behavior is indicated in the couple relationship, immediate behavioral principles would be applied, such as contracting. If the couple is unable to discuss differences without arguing, behavioral

therapy would be recommended, allowing the couple to experience positive communication when differences are present. If the couple experiences a significant amount of turmoil and fighting and are not speaking to each other, you can bet that they have very negative perceptions of each other. Cognitions related to their partner and the relationship itself (e.g., "it sucks") would need to be addressed through cognitive–behavioral therapy. A summary of the theoretical approaches used in this model is presented in Table 3.3.

**TABLE 3.3**
**Integration of Theories in Couple Therapy**

**Person-Centered Therapy**
Person-centered therapy serves as an overlay to all theoretical approaches used (integrated) when working with couples. The therapist works to meet the needs of the couple and allows them to tell their story. The therapist is therefore directed by the couple to proceed with what they want to work on during therapy. The therapist joins with the couple system by using the core conditions in counseling as the base of the relationship between the therapist and couple unit. These core conditions are emphasized with all of the theoretical approaches.

**Solution-Focused Therapy**
Solution-focused therapy encourages couples to seek solutions and tap internal resources. The focus is on change by helping couples work to find solutions to their problems rather than continuously rehashing the problem. The past, present, and future are discussed. When the past is reviewed, it is with the attention of what has worked in the past, rather than on how problems evolved. When the present is discussed, emphasis is placed on what is working and gaining an understanding of what the couple is doing right in order to make things work. There is a belief that all couples can muster their resources to make change within the couple system. A number of techniques are used, including scaling questions, the exception question, and the miracle question. The therapist plays an active role in keeping the couple focused on solving problems and coming up with solutions, rather than being problem oriented. Solution-focused work is intended to change the couple's thinking (perception), feeling, and behavior in the direction of examining and seeking what has worked, what can work, and what will work.

**Cognitive–Behavioral Therapy**
Cognitive–behavioral therapy focuses on faulty thinking that often leads to emotional and behavioral disturbances. Cognitions are considered a major determinant of how couples feel about and act toward each other. Therapy is oriented toward cognition and behavior, with emphasis on the role of thinking, deciding, questioning, doing, and redeciding. Therapy is often a process of learning new ways of thinking, practicing new skills, and acquiring more effective ways of coping with problems. In cognitive–behavioral therapy, the members' thought processes and perceptions of their spouse, as well as the couple system itself, are attacked. Cognitive–behavioral couple therapy attempts to clarify and change any faulty thought process connected with the relationship.

*(continued)*

**Structural Therapy**
Structural therapy helps couples understand how the system is structured, how balance or homeostasis is achieved, how feedback mechanisms operate, and how patterns develop. All couple systems have structures, with some being more functional than others. Couples often have a set hierarchy and preconceived boundaries as related to various issues. Roles, rules, and power within the couple system are emphasized.

**Behavioral Therapy**
Behavioral therapy focuses on overt behavior and measurable results. Precision takes place in specifying goals of treatment and developing treatment plans. Techniques such as modeling, cognitive restructuring, assertion, social skill building, behavioral rehearsal, and coaching are used. Contracts and homework assignments are typically used. Through the use of behavioral therapy, the therapist can clearly identify change made by clients.

In summary, integrative therapy combines theory throughout the course of therapy. The use of various techniques and concepts drawn from each theory is predicated upon the assessment process, the presentation by the couple, and the therapist's expertise in diagnosis. Even when following an integrative practice framework, the therapist should not be locked into his or her established theories. There will be occasions when the therapist will use concepts closely aligned with other approaches or theories. This is considered reasonable and responsible, with the caveat that the therapist has the expertise and training in those areas.

## Mega-Systems/External Factors

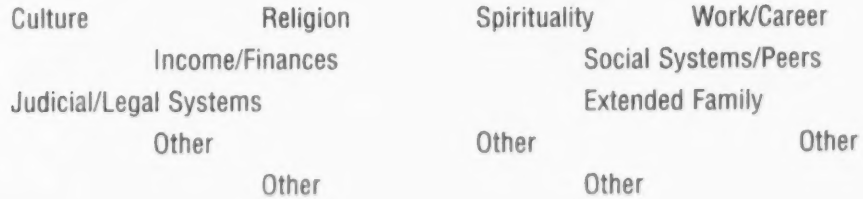
Mega, meaning large or great, refers to the many systems outside of the client/couple system that interact and affect the couple and individuals within that system. These are seen as extratherapeutic factors (Miller et al., 1997) and are viewed as affecting therapeutic outcome more so than the theory practiced or the relationship established. They include, in many cases, chance events in the lives of individuals and couples. These life events and external systems continuously interact with individuals and couples during and after therapy. These factors and systems are basically infinite and defy complete identification. Research has not been able to quantify the degree of influence each has on the well-being or health of individuals or couples. However, it is recognized that they have a major influence on therapeutic outcome and demand the attention

of therapists. Integrative therapists acknowledge and seek ways of working with mega-systems and factors affecting their clients and the course of therapy. Mega-systems and external factors include culture, work/career, peers, social systems, judicial systems, religion and spirituality, extended family, financial, and other similar units that interact with the couple system outside of therapy. Figure 3.4 provides a pictorial of several mega-systems and external factors that interact with couples.

There are many "other" factors and systems that interact with and affect the couple system. By regularly checking with the couple about their weekly activities, the therapist and the couple can identify other significant intervening factors. Some of the most powerful interactions with the couple can take place by accident or happenstance, allowing the therapist and couple no opportunity to prepare. There is a dearth of literature that assists integrative therapists in their work with mega-systems or extratherapeutic factors. Generally, most discussions have centered around the therapist becoming more sensitive or aware of the many systems and external factors that affect and often play havoc on the client's life. Yet, awareness and sensitivity are important steps that have helped many therapists better understand their clients and their life dilemmas. An increase in sensitivity and awareness has prevented a number of therapists from embarrassing themselves or potentially damaging their relationship with individuals and couples, particularly if clients represent a different culture or race. However, it is time we explored more active methods of working with couples to effectively influence and cope with factors external to therapy.

There are some actions or behaviors the therapist can use to affect external factors that impinge upon the couple system. By regularly checking with the couple about their outside-of-therapy weekly activities, the therapist can create opportunities for dialog about external factors currently affecting the couple and their relation-

**FIGURE 3.4**
**External Factors and Mega-Systems Affecting the Couple System**



ship. The therapist in many cases may need to become more assertive in his or her approach with the couple to discover significant external influences that would otherwise be ignored. The therapist may need to reframe her or his role and work as a change agent with the couple, mega-systems, and outside forces. The degree to which the therapist functions in a change agent role will vary. Some therapists may become more involved in home-based therapy and work closely with interacting forces such as the judicial system, the workplace, or school systems. The degree to which this is done could range from discussing strategies in the counseling session to helping arrange or attend meetings with systems that affect the couple's life. What the integrative therapist does in these cases will be tempered by his or her level of comfort and the degree of therapist involvement desired by the clients.

## Case: Couple X and Y

Working with couples from an integrative perspective requires that one is able to clearly conceptualize a model of integration and approach to therapy. The following case is presented to provide an example of how this integrative model would be used.

> X and Y came in for couple counseling. The wife (Y) made the appointment stating that there have been arguments between her and her husband (X). They have been married for 4 months and dated for about 6 months. This is the second marriage for Y, who has two young children through a previous marriage. The children, ages 3 and 5, live with Y's former husband and his mother's family, an arrangement that is satisfactory for X and Y. X has not been married previously. Both are of Hispanic origin. Both come from large families of their own with whom they currently have little contact. X works in a high-skilled computer position that has a lot of pressure. Y has an office job that she has worked in for several years. On the intake questionnaire, they rated the severity of the problem at a 3. They indicated that most of the decisions as well as many of the family rules were made by X. They described their relationship as uncomfortable right now and thought that it would get better only if their partner changed. The couple appeared stressed, seemed at a loss in their relationship, and were considering a separation and divorce.

From an integrative perspective, the therapist considers a number of important variables related to this case. First, the character-

istics of clients emphasize the importance of culture and family background. Possibly, traditional cultural norms and expectations are areas that would need to be explored (mega-systems). Gender issues and the developmental stage of the couple were matters of consideration. The therapist's own characteristics (the person as the therapist) and background (Caucasian) were areas of early review. In this case, the therapist had experience in working with Hispanic clients and couples in crises and felt comfortable working with this couple.

The process of therapy involved establishing a working relationship by using the core dimensions of counseling and following one's practicing integrative framework. Because the couple entered counseling in an arguing mood, perceived each other as the problem, and were ready to look at dissolving the relationship, solution-focused therapy was considered inappropriate. Using person-centered skills, the therapist listened to the couple and allowed them to reenact their arguments in session to gain a greater understanding of how they fight with each other (structural). Abuse, psychological or physical, was not evident, and contracting (behavior) around that was not essential. However, the therapist did some reframing (technique across theories) to help each partner see how his or her arguments and the spouse's behavior could be seen from a different perspective (cognitive–behavioral). Before the completion of the first session, the therapist provided a summary of what he heard and observed. The accuracy of this was checked with the couple. To prevent arguments from being exacerbated, the therapist provided the couple with some basic behavioral techniques (timeout, thought and argument stopping, listening and restating before disagreeing). The couple contracted with the therapist and each other to try these during the week. The therapist had the couple shake hands on this (first time they touched in a while). Also, examples of dirty fighting and rules for fair fighting were distributed so the couple could check to see if any of these had been used by themselves or their partner over the past few months. The couple did chuckle when quickly reviewing the list prior to the session closing.

The next session concentrated on maintaining the couple's ability to communicate without arguing. The couple applied many of the behavioral and effective communication principles and was ready to deal with differences at another level. Other concerns included many issues that were structural in nature. When the practicing integrative framework is used with couples, problems are often associated with hierarchy, roles, boundaries, spoken or nonspoken

rules, and related structural concerns. Because these were concerns already presented by the couple through the intake questionnaire, they were easy to address. In addition to working with the couple from a structural perspective, the therapist was able to use the genogram to examine mega-systems around culture and gender. Only after the couple was able to examine family of origin, culture, and gender role expectations, through the genogram, was the couple able to understand their differences and each other. Feelings, thoughts, and behaviors were examined over these issues, concentrating on the past, present, and future.

Cognitive–behavioral therapy was used in the next sessions to solidify perceptual change each had of the partner and of where the relationship was headed. The couple was actually able to see how their faulty thinking had developed and was used to disrupt their relationship. During treatment, the couple was encouraged to interact more with their families and culture with a new understanding and, in many cases, greater appreciation. The couple also was encouraged to talk about what they observed in their families and how it had influenced, and still does, their relationship. Before termination of therapy, the couple was asked to scale their presenting problem again (solution focused) to see where they were in terms of their arguing. Their new number was an 8, designating significant progress. The therapist reviewed with them how they got there, what they did to get there, and what a 9 would look like for them. The couple felt they could move to a 9 and presented some ideas on how to get there. Soon after, the couple and therapist decided that therapy was complete.

In a 2-month follow-up, X and Y reported still using much of what was covered in therapy. They were still functioning together at an 8, moving to a 9 level. When asked what was most helpful in therapy, neither partner mentioned a specific technique or theory. They spoke of the therapist's concern, understanding, and willingness to stick with them during some difficult times (relationship). They mentioned they were still doing more with their families, including Y's own children, and were gaining a better understanding about themselves as well as others in their family (mega-systems).

## Summary

It is believed that integrative therapy goes beyond theory and techniques. Counseling and therapy have become more scientific, with a greater awareness of what works in specific cases and how

outside forces can affect therapeutic outcome. Much is known about the importance of the therapist's own characteristics, the therapeutic relationship, and systems in therapy. Other factors, important as they are, have been overstudied and overemphasized. This includes the role of theory and technique in therapy. Yet, in the areas of theory and technique, there have been major strides in recognizing that single approaches or theories do not work with all client or couple issues and that many practicing therapists now integrate several approaches into their work. An important consideration now being recognized by therapists includes the many factors that interact and influence the couple system outside of therapy. Therapists have generally believed they had little control over these influencing elements, and in a number of cases this has been true. However, because of the significance attributed to external factors (mega-systems) affecting therapeutic outcome, we see a trend in examining ways to prepare clients to more effectively interact and cope with these factors that impinge upon their life. Understanding these larger systems and helping clients to more effectively cope with them are the greatest challenges for integrative therapists.

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# Biopsychosocial Therapy With Individuals and Couples: Integrative Theory and Interventions

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Biopsychosocial therapy is an integrative approach for conceptualizing and implementing treatment when biological factors present along with psychological and social/systemic factors. Biopsychosocial therapy is an integrative approach in two regards. First, it integrates or strategically *combines* various treatment modalities—individual, group, couple or family, and medication—as well as various methods—dynamic, cognitive–behavioral, systemic, and psychoeducational. Second, it integrates and *tailors* these modalities and methods to the needs, styles, and expectations of the client, be it individual client, family, or couple.

Biological factors are present in many individuals who seek mental health treatment today, including clients with depression, bipolar disorder, eating disorders, panic disorder, obsessive–compulsive disorder, and other anxiety disorders. Whenever biological factors are suspected, it is incumbent on clinicians, whether they are medical or nonmedical therapists, to formulate the case in biological as well as psychosocial terms. Such biopsychosocial formulations usually

lead to treatment plans that combine biological modalities with psychosocial ones. Whereas biological modalities usually refer to psychotropic medication, biological modalities also refer to nutrition modification, exercise prescription, alternative remedies such as melatonin, hypericum, or St. John's wort, as well as other medical treatments such as thyroid supplementation and hormone replacement therapy. Although using certain biological modalities in psychotherapy may be outside the clinician's scope of practice, effective and ethical treatment requires appropriate referral and collaboration. Increasingly, nonmedical therapists begin working with an individual or couple with biological factors, make an appropriate medical or psychiatric referral, and then continue their psychotherapeutic interventions in isolation from the prescribing clinician's intervention. Issues such as responsibility for after-hours and vacation coverage, the client's safety and legal liability, and "splitting" may never be discussed by the various providers. Biopsychosocial therapy emphasizes the dimension of collaborative clinical practice between and among various providers.

This chapter describes and illustrates the theoretical premises and the clinical applications of the biopsychosocial therapy approach. It also describes and illustrates four stages of treatment and therapeutic techniques and tactics associated with these stages. The discussion begins with the theory of the biopsychosocial perspective, examines the significance of the biological dimension within the biopsychosocial perspective, describes the stages and tactics of focus of biopsychosocial therapy, and then lists typical clinical indications for this approach. Finally, two extended case examples are provided to illustrate the application of this approach to individuals and couples.

## The Biopsychosocial Perspective

The biopsychosocial model is a holistic and systems perspective for understanding the person and the relationship of the system outside and inside the person that influences both health and illness (Engel, 1977; Sperry, 1988b). The model proposes that a client can only be adequately understood if the therapist considers all levels of his or her functioning: biological, psychological, and social. Biological functioning refers to all peripheral organ system functions as well as to all autonomic, neuroendocrine, and central nervous system functions that are subcortical, that is, to all processes that are automatic and outside conscious awareness.

Psychological functioning refers to the self-conscious inner world that directs information processing and communication from and with the outside world. It basically involves cortical structures and conscious awareness. It also includes the internal representation of self, the world, and personal goals, which reflects aspirations, ideals, needs, and the cognitions and strategies that govern behavior. Social functioning refers to the person's behavior in relation to family, friends, authorities, peer group, and cultural expectations, as well as community institutions that influence and are influenced by the individual. Some might add that a truly holistic approach would include the spiritual or life-meaning dimension of functioning.

## The Significance of the Biological Dimension in the Biopsychosocial Perspective

Until recently, training in psychology and the behavioral sciences has almost exclusively been directed at the psychosocial dimension of behavior. In the past decade, however, this has begun to change. Training programs in the behavioral sciences, particularly graduate programs in psychology, have begun to require some training in biology, that is, the biological bases of behavior, neuropsychology, cognitive neuroscience, psychopharmacology, and so on. This is occurring for at least two reasons: first, because of advances in the understanding of brain–mind interactions on behavior and the retrieval of the temperament dimension of personality; second, because the professional practice of psychology has shifted its identity from being a mental health specialty to a health care specialty. This section describes some of the ways in which the biological dimension affects the social and intimate relationships of committed couples. It first describes the biological dimension in terms of temperament and brain systems and its interaction with the psychosocial dimensions of the biopsychosocial perspective. Then it illustrates this interaction with a case example.

### *Temperament*

Recently, the earlier formulation of personality as the interaction of character and temperament has been retrieved (Sperry, 1999). Character refers to the learned, psychosocial influences on personality. Character forms largely because of the socialization process, particularly regarding cooperativeness, as well as because of the

mirroring process that promotes the development of self-concept and a sense of purpose in life (i.e., self-transcendence and self-responsibility). Another way of specifying the characterological component of personality is with the term *lifestyle* or *schema*. Temperament refers to the innate, genetic, and constitutional influences on personality. Whereas character and schema reflect the psychological dimension of personality, temperament reflects the biological dimension of personality. Researchers including Cloninger, Svrakic, and Prybeck (1993) have contended that temperament has four biological dimensions: novelty-seeking, harm avoidance, reward dependence, and persistence, whereas character has three quantifiable dimensions: self-directedness or self-responsibility, cooperativeness, and self-transcendence. Other researchers would describe impulsivity and aggressiveness as additional dimensions of temperament (Costello, 1996). Later, it will be noted that these various temperament traits appear to be associated with specific brain circuits or systems.

Temperament and character can be assessed by interview and self-report instruments. The relevance of distinguishing character and temperament for treatment planning is significant. Whereas insight-oriented psychotherapy may be focused on the character dimensions, psychotherapy tends to have little or no impact on temperament dimensions. For example, where dysregulation of temperament is significant (i.e., high levels of impulsivity and aggressiveness are present), medication and behavioral interventions and focused skill training may be effective in sufficiently regulating or modulating an individual's affects and behaviors so that he or she could then profit from individual and group therapy directed at the character dimensions.

### *Brain Systems*

The brain and neurophysiology appear to significantly influence intimate relationships. Essentially, the brain consists of various circuits or systems with specialized functions that have been shown to predictably influence and modulate specific patterns of thoughts, feelings, and behavior. Research based on brain imaging has proved extremely valuable for clinical practice (Amen, 1994; Amen & Waugh, 1998; Wu, Amen, & Bracha, 2000). Following is a brief description of some brain systems that influence and mediate social and intimate relationships. It appears that specific temperament of traits (e.g., impulsivity, aggressivity, and compulsivity) are associated with specific brain systems.

The *limbic system*, located in the center of the brain, largely controls mood and bonding behaviors. When the limbic system is functioning optimally, individuals tend to be more positive and more able to connect with others. They usually filter information accurately and tend to give others the benefit of the doubt. They find it relatively easy to bond with others, to be playful, and to relate sexually with their partner. Furthermore, they can easily access positive emotional memories. Because of their positive attitude, they tend to draw people toward them. When the limbic system is overactive, however, individuals tend toward depression and negativity, and they distance themselves from others. They are more likely to focus on the negative aspects of others and think and speak in pessimistic terms. Accordingly, their memories tend to be negative, and they find it difficult to access positive emotional memories or feelings. Furthermore, they are likely to avoid sexual activity because of a lack of interest or to push others away with their negativity.

The *basal ganglia* system basically controls a person's level of activity. When the basal ganglia system functions properly, people tend to act in a calm and relaxed manner. They are likely to exhibit a positive outlook on life and to manifest an optimistic view of the future, and they are usually able to deal with conflict effectively. They tend to feel good about their bodies and can be sufficiently relaxed enough to be playful and sexually intimate. However, when the basal ganglia are overactive, individuals tend to be anxious, fearful, and tense. They may even experience full-blown panic symptoms. Because they filter information through fear and seldom give others the benefit of the doubt, they are likely to focus negatively on future events and have a propensity to catastrophize. They may regularly experience headaches, muscle aches, and pains and are often plagued with multiple physical complaints. Because they are constantly tense, they are likely to have reduced libido (i.e., lowered sexual interest). Not surprisingly, they seldom have the physical or emotional energy to feel sensual or sexual, so they make excuses to avoid sexual activity. Their memories are often laced with anxiety or fear, and they get reputations as worriers because of the constant fear they project.

The *cingulate* is the brain system that shifts attention from thought to thought and between behaviors. When the cingulate functions properly, individuals are able to shift their attention easily. Thus, they are often flexible and adaptable and tend to see possibilities and options even in difficult situations. Furthermore, they tend to have a positive outlook, view the future with hope, and easily adapt

to the ups and downs of relationships. Instead of holding on to hurts from the past, they can forgive the mistakes of others. They encourage others to help but do not feel compelled to rigidly control situations and circumstances. When the cingulate is overactive, however, individuals have a tendency to obsess and ruminate. Furthermore, they are likely to hold grudges and hurts from the past and to be unforgiving of perceived wrongs. They have a tendency to be inflexible, rigid, and unbending, and they may demand that things be done a certain way and become upset when things do not go their way. Dealing with change is difficult for them. Finally, they are likely to become argumentative and oppositional.

The *prefrontal cortex* is the brain system involved with executive functions, that is, making plans, controlling impulses, making decisions, and maintaining focus. When the prefrontal cortex functions properly, individuals tend to engage in goal-directed behavior and can effectively monitor their words and actions. They are able to think before they speak and are likely to say things that affect their goals in a positive way. They also tend to think before they act, and their actions are consistent with their goals. Because they tend to learn from mistakes, they are unlikely to make the same ones over and over. In addition, they can focus and attend to conversations, organize their actions, and follow through on commitments. They can become centered and grounded easily. They are able to express what they feel and tend to avoid conflict, tension, and turmoil. When the prefrontal cortex is underactive, however, individuals tend to speak and act impulsively, which can negatively and seriously affect relationships. They tend to live in the moment and have difficulty delaying gratification, and they seldom learn from their mistakes. Furthermore, they tend to be easily distracted and have trouble listening. Because they are likely to have difficulty expressing their thoughts and feelings, their partners often complain of a lack of communication in the relationship. Such individuals tend to be restless and fidgety and find it difficult to become still and centered. It has been observed that they can be extremely sensitive to noise, smells, light, and touch. Staying on task, being punctual, finishing projects, and keeping commitments are difficult for them. In addition, many individuals with prefrontal cortex problems have an unconscious tendency to seek conflict or to look for problems when none exist. Finally, they tend to seek stimulation or indulge in highly stimulating behaviors that upset or frighten their partner or others in their relationships. Not surprisingly, the diagnosis of attention deficit hyperactivity disorder (ADHD) can frequently be made in such individuals.

The *temporal lobes* are the brain system involved with temper control, facial recognition, understanding language, and memory. When the temporal lobes function properly, individuals tend to be emotionally stable. They can effectively process, understand, and recall what has been communicated and can accurately discern the emotional state of others. Because of their capacity for accurate recall, they have a sense of personal history and identity. Finally, they tend to have excellent impulse control. When the temporal lobes do not function properly, however, individuals are often emotionally labile, tend to be temperamental, and have problems with anger. Memory difficulties may be related to their distorted sense of personal history and identity. They may experience violent thoughts and express their frustration with aggressive talk. When stressed, they can become confused and misinterpret visual and verbal cues.

### *Clinical Application*

The question might be asked: Could these presentations just as easily be attributed to psychological and characterological explanations rather than these biological and neurophysiological explanations? Yes, they could. But the more compelling explanation or formulation is the one that is associated with high responsivity to a targeted treatment; thus, a quick response to a biological treatment, such as medication, argues well for a case formulation that includes the biological dimension. In other words, the proof is in the proverbial pudding. The following example illustrates such a case.

Jay and Jody had been in couples therapy for 4 years. Because of the therapist's frustration with the little progress that had been achieved, she arranged for a second opinion, in the form of a psychiatric consultation for this seemingly "resistant couple." Because of their mutual commitment to the relationship and their regard for their couples therapist, the couple agreed to the second opinion.

The chief complaint and pattern of their relationship was constant, ongoing marital conflict. The couples therapist had begun systemic interventions with the hope of restructuring the relationship. With little noticeable effect, she switched to strategic and behavioral interventions, and in the year prior to the consultation, focused on psychodynamic issues. During this time, she saw each spouse for weekly individual sessions as well as conjoint sessions.

Jay usually triggered such fights with verbal assaults on Jody. He typically worked 60 or more hours per week, although he admitted he was not anymore productive than his peers who worked consid-

erably fewer hours. Over the past 6 years, he has had two affairs. The psychiatric evaluation confirmed the couples therapist's suspicion of a diagnosis of ADHD in Jay. The history indicated that he had been restless, inattentive, disorganized, and impulsive throughout the course of his formal schooling, and his achievement was minimal in contrast to his abilities. His concentration difficulties compounded his interpersonal relationships. Not only did he have difficulty listening to teachers and later work supervisors, he was also a poor listener with Jody. His brief marital affairs seemed to be impulsive rather than premeditated liaisons. Furthermore, it appeared that he easily provoked conflicts and inflamed situations by making thoughtless remarks. Jody also appeared to contribute to the marital turmoil. She was quite angry and resentful about the conflictual nature of their marriage and had experienced periods of depression over the past 10 years. She came across as inflexible and rigid and could not imagine ever forgiving Jay for his affairs or other perceived wrongs. The developmental and social history revealed a consistent pattern of arguing over insignificant matters and Jody's repeated voicing of the same complaints about others, not just Jay. In addition, there was lifelong history of chronic rumination and worry and a trigger-hair temper. It is noteworthy that when things did not proceed exactly the way Jody believed that they should, she would become and remain upset for several hours or days without respite. These worries and demand seemed to be an endless loop. Try as she might, she just could not break off or let go of these thoughts, expectations, demands, and worries.

Needless to say, in addition to clear psychosocial dynamics, there was a biological "feel" to this couple's presentation. While Jay manifested a propensity to *under*focus, Jody exhibited the tendency to *over*focus, which taken together fostered and reinforced conflict in their relationship. Unfortunately, none of the psychosocial formulations or interventions used seemed to be able to neutralize or change this relationship pattern. In cases such as this, where there has been competent professional care provided, there is desire and motivation on the part of the client or couple to improve, and little or no progress in therapy has been achieved, exploring the biological dimension is certainly reasonable.

The diagnosis of ADHD in Jay was suggestive of decreased activity in his prefrontal cortex. Such conditions are often quite responsive to psychostimulant medications as Ritalin or Adderall. Jay had begun a standard adult dosing schedule of Adderall. Within 7 days, he reported being more focused and organized at work. He acted in a more thoughtful and positive manner in his relationship with Jody.

Jody's pattern of "looping" thoughts, demands, and worries, and her unforgiving attitude, inflexibility, rigidity, and constant complaining were suggestive of increased activity of the cingulate system. Because serotonergic antidepressants such as Prozac, Zoloft, Paxil, and Celexa have been demonstrated to decrease the tendency to overfocus, a trial of Celexa was suggested to Jody. Although somewhat skeptical of taking a "mind-altering" drug, she was willing to give the medication a try for 4 to 6 weeks. By the middle of the 4th week, she reported a number of changes. Her thoughts no longer looped, and she seemed less ruminative, demanding, and worrisome. She also reported that it was easier for her to control her temper, to hold onto positive thoughts, and to be more relaxed and playful. As a result, Jody was able to spend time together with Jay without constant conflict. They continued in couples therapy for about 3 months and were, for the first time, able to use the relationship techniques learned in therapy. Both remained on medication during this period and subsequent to their planned termination of couples therapy.

## History and Development of Biopsychosocial Therapy

Biopsychosocial therapy is a systematically eclectic approach to therapeutic intervention that was formally described and articulated by Len Sperry in 1988 (Sperry, 1988a). It is not so much a uniquely new treatment approach as it is an articulation and systemization of a way of conceptualizing treatment planning on the basis of biopsychosocial and teleological principles. Because of its comprehensive and integrative emphasis, it is particularly appropriate for cases that are termed difficult or treatment resistant, or where there is comorbidity of various medical and psychiatric conditions. Evaluating an individual from a biopsychosocial approach oftentimes indicates the reasons for such difficult and resistant cases.

Biopsychosocial therapy involves three distinct but interrelated stages: evaluation, formulation, and treatment plan (Sperry, 1988b). A biopsychosocial evaluation includes a systematic review of the presenting complaint, past treatment history, mental status examination, social–developmental history, and relevant medical conditions and health habit, as well as family history of emotional dysfunction. A biopsychosocial formulation should provide an integrative explanation of the individual's current level of functioning in light of present and past antecedents. Biological factors, particularly predispositions, medical conditions, and health habits,

are correlated with psychosocial factors. A summary of family constellation and early recollections data are reported in the present case. A list of short- and long-term problems, along with a five-axes *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM–IV*; American Psychiatric Association, 1994) diagnosis is standard. Finally, the formulation suggests treatment focus and speculates on prognosis. A biopsychosocial treatment plan specified the treatment outcomes and the nature of the treatment contract or contracts if treatment is likely to proceed in more than one phase. It also indicates the decisions made about the setting, mode, duration, and treatment strategies and techniques for accomplishing the treatment outcomes.

The question becomes: What is a "treatment-receptive" client, and how can those who are less receptive become treatment-receptive such that psychopharmacological treatment be maximized? This chapter addresses these two questions by describing four treatment strategies that have been shown to maximize treatment outcomes when psychotropic medications are indicated. These overlapping strategies are designed to assist the provider in planning and implementing tailored, focused treatment.

Optimal treatment outcomes presume that a client is prescribed and uses the most efficacious treatment. This presumption is seldom met in clinical practice. Even if the most potent, focused, and tailored treatment is prescribed, it cannot be assumed that the client will commit to and cooperate with the treatment over an extended period of time. The treatment-responsive client is able to make and keep this commitment. The challenge for providers—both those who are prescribers and those who are therapists if joint treatment is involved—is to expect and facilitate treatment responsiveness in their clients. Four treatment stages have been noted to optimize treatment response and outcome (Sperry, 1995; Sperry, Brill, Howard, & Grissom, 1996): (a) engage the client (and other provider or providers) in a collaborative relationship; (b) perform a comprehensive functional assessment; (c) decrease symptomatology and increase functioning; and (d) maintain treatment gains and prevent recurrence. These stages are not unlike the phases of treatment that Beitman (1993) found were common to most Eastern and Western therapy systems and approaches. Rather, these stages have been configured and fashioned to the particular needs of clients and couples presenting with a complex of symptoms, functional impairment, and concurrent medical or psychiatric conditions, such as characterological features that undermine or complicate treatment, unresponsiveness to treatment, or the presence

of additional clinicians involved with the case. Three treatment tactics that relate to the third stage are also highlighted: combining treatment modalities, enhancing treatment compliance, and incorporating psychoeducational interventions. Along with the four stages, these three tactics are discussed and illustrated below.

## Biopsychosocial Therapy in Clinical Practice

### *Engaging the Client in a Collaborative Relationship*

The first treatment strategy is to engage the client in a collaborative relationship. Premature termination, treatment failure, and partial treatment success are often the result of inadequate engagement (Sperry, 1995). Usually, this is due to the clinician's unwarranted assumption that the client is ready and motivated to collaborate in the change process. Thus, rather than viewing engagement as *the* primary treatment strategy, the clinician proceeds with assessment and changes intervention strategies and methods. Research suggests that when clients are not ready or willing to engage in a collaborative treatment process, noncompliance, partial response, and premature termination can be expected (Beitman, 1993).

Having two or more clinicians involved in the treatment process can further complicate the engagement and collaboration process. This occurs when one clinician provides individual therapy and another clinician provides another psychosocial modality, such as family or group therapy, or prescribes medication. This can occur because the collaborating clinicians tend to have different treatment focus and goals and relate to the client differently in terms of duration and frequency of sessions. While the prescribing clinician may be principally focused on managing relationships with the client to maximize medication compliance and increase a positive placebo response, the nonmedical therapist is principally focused on enhancing the client's self-management and interpersonal relationships functioning. Often, the two collaborating clinicians will differ in gender, age, interpersonal style, professional discipline, and attitudes toward somatic and psychosocial therapies. Not surprisingly, the treatment process can be quite complicated, and interactional phenomena such as projective identification and splitting are commonplace.

Active and purposeful collaboration among the clinicians and the client are essential not only to facilitate engagement but also for overall treatment efficacy. When the roles of both clinicians are

clearly distinguished, frequent discussions about the client and treatment goals can facilitate treatment outcomes (Woodward, Duckworth, & Guthiel, 1993). The quality of clinician–clinician collaboration is crucial to treatment, and mutual respect, trust, and openness are necessary in developing an effective collaboration. Collaborative communication is useful in sensitizing both therapists to each other's concerns. For instance, because the nonprescribing clinician sees the client more frequently, he or she should be able to recognize early signs of hypomania in a client who is taking an antimanic medication. Or, the prescribing clinician, concerned that a client's irritability might be a side effect of fluoxetine (Prozac), can learn from the other clinician that the client is usually irritable.

### *Performing a Comprehensive Functional Assessment*

The second treatment strategy is to perform a comprehensive functional assessment. Functional assessment should include two client characteristics that are predictive of treatment responsiveness and, hence, positive treatment outcomes. These two characteristics are treatment readiness and explanatory model (Beitman, 1993). Treatment readiness refers to the client's motivation and capacity to cooperate with treatment. Assessment of treatment readiness and prompting and facilitating the highest level of readiness that the client is capable are particularly important when psychotropic agents are the principal treatment modality.

Explanatory model is the client's personal interpretation or explanation of disease and symptoms. This model can be fraught with misinformation or misattribution. Such "explanations" become the basis for client education and negotiation. For instance, clients with bipolar disorders who believe that their illness was caused by insomnia and can be cured by a good night's sleep need to have their "explanation" corrected. Similarly, the client who explains the experience of generalized anxiety in terms of a single early life trauma should hear the provider describe a more complete model of the illness that also allows for these particular concerns about the early trauma. Specific irrational beliefs about illness or treatment must also be elicited and addressed. The delusional belief that the medication to be prescribed is a poison is one obvious example. A less obvious irrational belief involves clients with low self-esteem. They may ascribe negative meaning to medication, viewing it as representative of their personal deficiency or worthlessness. This projected badness can then be externalized and dismissed by refusing

to accept the medication and thus protecting themselves from further loss of self-esteem. Helping clients understand their illness is best done in a biopsychosocial context, particularly for those clients seeking the magic pill. Negotiated explanations that are tailored to the client's experience are particularly valuable. Such an explanation should be simple, integrate biological and psychosocial mechanisms, and incorporate some elements of the client's explanation. For example, a schizophrenic male client may accept that he has a biochemical imbalance that leaves him overly reactive to his environment and other people—the perceptual filter model of psychosis—resulting in social withdrawal and simple phobia. Or, the client insisting that hypoglycemia is the basis for his major depressive episode might be offered a treatment plan in which blood glucose would be checked immediately and reevaluated if a 4-week trial of medication is not successful. Finally, medication can be perceived as both a vehicle and an agent of control. It may be viewed as a chemical means by which the clinician exerts control over the client's thought or action, and thereby, the client's noncompliance is a means of controlling and defeating the clinician. Similarly, noncompliance may function as a projective identification, as when the client's feelings of helplessness are projected onto and induced in the clinician.

Although the current diagnostic system (*DSM–IV*) may have research and administrative value in specifying diagnosis across a range of clients, it is seldom clinically useful in evaluating clients for treatment planning purposes. In addition to the obvious problem of depending on somewhat arbitrary diagnostic categories and criteria, these criteria do not currently distinguish between symptomatic distress and functional capacity, nor does it address the matter of readiness for change. Clinically speaking, these factors are critical in planning treatment and predicting outcome. An evaluation model that specifies five dimensions is recommended: presentation, pattern, predisposition, perpetuants, and readiness for treatment (Sperry, 1995; Sperry, Gudeman, Blackwell, & Faulkner, 1992).

*Presentation* refers to a description of nature and severity of the individual's psychiatric presentation. It can include the type and kind of symptoms (i.e., acute, warning, or persistent), level of life functioning (i.e., self-management, family, intimacy, work, social, and health), past history, and course of the illness.

*Pattern* refers to the predictable and consistent style or manner in which a person thinks, feels, acts, copes, and defends the self both in stressful and nonstressful circumstances. It reflects the

individual's baseline functioning. This pattern has physical, psychological, and social features, such as a sedentary and coronary-prone lifestyle, dependent personality style or disorder, or collusion in a relative's marital problems. Pattern also includes the individual's functional strengths, which counterbalance dysfunction. One way of specifying pattern is with *DSM–IV* Axis II personality traits or disorder terms.

*Predisposition* refers to all factors that render an individual vulnerable to a disorder. Predisposing factors usually involve physical, psychological, and social factors. Physical or biological factors include genetic, familial, temperament, or medical patterns, such as family history of a major psychiatric disorder, an organ inferiority, family history of substance abuse, a difficult or slow-to-warm-up child temperament, or cardiac disease or hypertension. Psychological factors might include dysfunctional beliefs or convictions involving inadequacy, perfectionism, or overdependence, which might further predispose the individual to a medical disorder, such as coronary artery disease. Psychological factors might involve limited or exaggerated social skills, such as lack of friendship skills, unassertiveness, or overaggressiveness. Social factors could include early childhood losses, inconsistent parenting style, overly enmeshed or disengaged family of origin, or a family constellation characterized by dogged competitiveness or emotional surveillance. Subcultural, financial, and ethnic factors can be additional social predisposers.

*Perpetuants* refer to processes by which a client's pattern is reinforced and confirmed by both the client and the client's environment. These processes may be physical, such as impaired immunity or habituation to an addictive substance; psychological, such as losing hope or fearing the consequences of getting well; or social, such as colluding family members or agencies that foster disordered behavior rather than recovery and growth.

*Readiness for treatment* refers to the client's desire for and capacity to make therapeutic changes. Readiness involves three components: treatment expectations, treatment willingness, and treatment capability (Sperry, 1995). Though related, each of these three is a relatively independent marker of readiness. Clients can have high, low, or ambivalent expectations for change, and these expectations may be realistic or unrealistic. Generally speaking, clients with moderate to high realistic expectations of change do change more than clients with unrealistic or minimal expectations. Treatment willingness reflects the client's potential or likelihood for change. Normative stages or levels of change have been noted

in psychotherapy and pharmacotherapy (Beitman, 1993). The stages are as follows: *precontemplation*, the denial of need for treatment; *contemplation*, the acceptance of need for treatment; *decision*, agreeing to take responsibility and collaborate with treatment effort; *action*, taking responsibility and collaborating in change effort; and *maintenance*, continuing effort and avoiding relapse (Prochaska, Rossi, & Wilcox, 1991). Knowledge of treatment willingness or stage of change is critical in predicting treatment outcomes because clients who have accepted the need for treatment, decided to cooperate with treatment, and have made efforts to change and maintain change are more likely to have positive treatment outcomes than clients who do not. Treatment capability reflects the degree to which clients are capable of controlling or modulating their affects, cognitions, and impulses. As such, they are psychologically available to collaborate in treatment in comparison with clients who are continually parasuicidal or who engage in treatment sabotage or escape behaviors (Sperry, 1995). Patterns have traditionally been the focus of instrumentation in psychological assessment and the basis for a comprehensive psychiatric interview. Clinicians who can effectively elicit and articulate information on pattern as it is distinct but complementary to predispositio.., perpetuants, and treatment readiness are cognitively aided in both case formulation and treatment planning.

### *Decreasing Symptomatology and Functional Impairment*

Decreasing symptomatology and increasing life functioning, the third treatment strategy, are the essential goals of all therapy systems and approaches. Individuals and couples who present for mental health treatment in symptomatic distress are seeking relief from symptoms they have not been able to reduce by their own efforts. Thus, symptom reduction or removal is one of the first goals of treatment. Usually, this goal is achieved with medication or behavioral interventions or both. According to phase theory, as symptoms increase, one or more areas of life functioning decrease, and therapeutic efforts to increase functional capacity tend to be thwarted until symptomatology is decreased (Sperry et al., 1996). Six areas of life functioning that the Social Security Administration considers in making a determination of health or disability are self-management, health and grooming, family, social, intimacy, and family functioning. Along with levels of symptomatology, these areas of functioning are measured and monitored in current psychotherapy

treatment outcome systems (Sperry et al., 1996). Most individuals who present for biopsychosocial therapy have problems with both symptomatic distress and functional impairment, and many have only partially responded to previous therapy, usually single-mode, single-approach treatment. Thus, it is incumbent on the clinicians practicing biopsychosocial therapy to formulate a treatment plan comprehensively and integratively.

There are three treatment tactics related to this third stage that can ensure and optimize the likelihood of reducing symptoms and increasing functional capacity. They are combining treatment modalities, enhancing treatment compliance, and incorporating psychoeducational interventions. Effective utilization of these tactics will increase the likelihood that treatment will be optimized.

Combining treatments or combined treatment refers to including additional modalities to the primary modality. When a client begins a course of psychotherapy during which increasing symptoms preclude the client from adequately functioning in relationships or on the job, medication may be combined with the primary modality. When medication is the primary modality but issues of medication compliance or the client's safety become an issue, individual psychotherapy, group psychotherapy, couple, or family therapy is typically added to the medication management treatment to increase treatment response and outcomes. It may simply be that group or family therapy is combined with individual therapy. Or, as in the first case example presented below, three modalities may be combined: individual therapy, family therapy, and medication.

Enhancing medication compliance is a major challenge facing both prescribing and nonprescribing clinicians. Key factors that are known to affect compliance include client factors, provider–client interaction, the treatment regimen itself, and family factors. The placebo effect refers to the belief and expectation that the client will positively respond to treatment. It is operative anytime in any clinical situation, specifically when medication is involved. The placebo effect can be enhanced or triggered in several ways: by spending time with the client especially at the outset of treatment, by expressing interest and concern, and by demonstrating a confident, professional manner (Sperry, 1995).

Incorporating psychoeducational interventions is a powerful optimizing tactic in psychopharmacotherapy. Psychoeducation refers to much more than merely explaining the medication, dosing schedule, and side-effect profile. Psychoeducation includes drug information sheets, client education videos, medication groups, self-help organizations, support groups, social skills training, and more.

Incorporating psychoeducational strategies and tactics in medication management is almost always essential to achieve symptom amelioration, particularly in the long term.

### *Maintaining Treatment Gains and Preventing Recurrence*

Finally, maintaining treatment gains and preventing recurrence is the fourth treatment strategy. Technically, relapse refers to a continuation of the "original" episode, whereas recurrence is the instigation of a "new" episode. For this discussion, both terms are used synonymously. To prevent relapse, the provider must assess the client's risk factors and potential for relapse and incorporate relapse prevention strategies into the treatment process.

## Clinical Indications for Biopsychosocial Therapy

The clinical indications for the four biopsychosocial therapy strategies just described can be stated in both broad and narrow terms. In broad terms, all four strategies are indicated in instances when an adult client or a couple exhibits significant symptomatic distress and considerable functional impairment, particularly when biological factors are implicated (as in most severe Axis I disorders); has a concurrent Axis I, II, or III condition that complicates treatment; and has not responded to a single modality or approach treatment; as well as when there is more than one clinician providing treatment to the client or couple.

In narrow terms, each of the four strategies has more specific indication and contraindications, particularly the three tactics associated with the third strategy, decreasing symptomatology and functional assessment. Space precludes a detailing of them here.

## Clinical Applications With Individuals

Jessie L. was a 37-year-old never-married, White female administrative assistant who presented with a 2-week onset of depressed mood. Other symptoms included loss of energy, markedly diminished interest, insomnia, difficulty concentrating, and increasing social isolation. She had not shown up for work for 5 days, prompting the psychiatric referral. Cutbacks at her office led to her being transferred out of a close-knit work unit where she had been for 15

years to a promotion as a senior administrative assistant position for the new vice president of sales in the executive annex. Jessie experienced this transfer as a significant loss, which apparently triggered her depressive symptoms and increased social isolation. No personal or family mental or substance-related history was reported. She denied current medical problems or the use of prescription or over-the-counter medications. She reported living alone in a duplex in a quiet residential neighborhood. In addition, she indicated that she had one close female friend at her office and that she had not been involved in an intimate relationship since college. Jessie had worked at the same company since graduating from a 2-year business college program at the age of 22.

### *Engaging the Individual in the Treatment Process*

As is often the case with shy or avoidant clients, Jessie showed up late for the initial evaluation. She indicated she had come only at the insistence of the director of human resources, and while she admitted she felt awful, she was sure she did not need treatment. Self-disclosure was clearly difficult for her. She did, however, view her job transfer as a significant loss and tentatively agreed that it might have triggered her depressive symptoms and isolative behavior. Because there was no indication that she was a danger to herself, it seemed likely that outpatient treatment was possible. In taking the history, the clinician became increasingly aware of Jessie's longstanding hypersensitivity to criticism. Accordingly, as the formulation of her avoidant personality style emerged, the clinician was notably gentle and supportive verbally and nonverbally.

Avoidant individuals tend to test and provoke clinicians in several ways in early sessions. For example, such clients tend to be quite good at provoking clinicians to criticize them for being late or for changing or canceling appointments. Accordingly, near the end of the first session, the clinician made a predictive interpretation that Jessie would probably have a difficult time making and keeping subsequent sessions. Because of this prediction, needless to say, the appointment was made with relative ease and Jessie arrived at the second session on time.

Because of the complex clinical picture of clients seeking biopsychosocial therapy, combined treatment is often a consideration. Thus, it is incumbent on the clinician to establish collaborative relationships with other possible providers, such as prescribing a psychiatrist, group or family therapist, or consulting medical specialist. In the case of someone with avoidant personality dynamics,

it is predictable that the client will "test" the prescribing physician and group therapist's trustability and criticalness. Consequently, in this present case, these considerations were shared and discussed with collaborating clinicians—a prescribing physician and a group therapist.

### *Performing a Comprehensive Functional Assessment*

Jessie's score on the Beck Depression Inventory given after the initial session was 28, indicating a moderate–severe level of clinical depression. The profile on Jessie's Millon Clinical Multiaxial Inventory III (MCMI-III) suggested the diagnosis of major depression and avoidant personality disorder.

Family constellation data reveal that Jessie was the older of two siblings; her only brother was 3 years younger, married with three children, and employed as a computer programmer for an insurance corporation. Both parents are alive and relatively healthy. Jessie's father had worked as a senior account executive until the firm he had been at for 30 years had downsized and forced him into early retirement 2 years later. Two years ago her parents relocated to a retirement village in Florida. Jessie's mother never worked outside the home. Family values included achievement, social conformity, and family loyalty.

Jessie thinks she was most like her mother but has had a somewhat distant relationship with her both as a child and even now. However, Jessie does recall being spoiled by her aunt, her mother's youngest sister, until she died of cancer when Jessie was 8 years old. Jessie believes her brother was the favorite of both her parents. She recalls having few friends growing up, after her best friend moved away when Jessie was 8 years old. She also recalls being ridiculed by others for being somewhat obese and "clumsy" in junior and senior high school. She seldom dated in high school, although she was invited but did not attend either the junior or senior prom. In college, she had a few dates with fellow students that seldom involved any sexual activity.

Her earliest childhood recollection involved seeing her infant brother for the first time when she was 3 years old. She recalls her parents had just returned from the hospital. Jessie had been frightened staying with her aunt and not knowing where her mother had gone. Her mother lovingly placed her baby brother in Jessie's old crib, while Jessie's father said that the birth was the happiest day of his life. Jessie was told to stop whining and asking questions about the baby and to go outside to play or she would be punished. She

remembers running outside crying and hiding in her tree fort until it got dark. She felt frightened and confused. Jessie described intense feelings of humiliation and rejection following the birth of her younger brother. A second recollection is reported when she was about 5 years old. Jessie was supposed to have been watching her brother in the playroom while his mother went in the kitchen to make lunch. Unbeknownst to Jessie, her brother had taken a small plastic toy apart and stuffed a piece of it up his nose where it lodged, leading him to begin screaming. Responding to the crying, the mother spanked Jessie for being a disobedient and uncaring sister. Jessie recalls running to her room crying and feeling hurt for being unjustly punished and unloved because her mother gave so much attention to her brother. In short, she experienced her brother's birth and subsequent spoiling by her parents as the nullification of the sense of specialness and nurturance by her parents she had previously enjoyed.

The following diagnostic and clinical formulation was developed. Jessie's history and mental status exam were consistent with major depressive episode. In addition, she met criteria for avoidant personality disorder. The *diagnostic formulation* includes an Axis I diagnosis of major depressive disorder, single episode, moderate and occupational problems, with an Axis II of avoidant personality disorder.

The following *clinical formulation* was specified: Jessie came to believe that the opinions of others were all that counted. Yet, she was teased and ridiculed by her peers for her personal appearance, especially her obesity. There were also strong parental injunctions against discussing important matters with "outsiders." She typically distances and isolates herself from others when she is in unfamiliar or in close interpersonal relations. Presumably, she anticipates and fears the disapproval and criticism of others. She views others as critical and harsh and is convinced she is viewed by others as inadequate. Therefore, she is slow to warm up and trust others, and she "tests" others' trustability by being late for or canceling or missing agreed-upon engagements. Lack of social skills in relating to new or less-known individuals and a limited social network further contribute to her isolative lifestyle and reinforce her beliefs about self, the world, and others. Interestingly, she describes herself as a wallflower who spent much of her time reading romance novels, watching soap operas, or knitting. With the exception of intimacy and social relations, she had functioned above average in the life task of work. She agreed she was severely depressed and was willing to comply with combined treatment in-

volving medication started and monitored on an outpatient basis along with time-limited psychotherapy. She did not appear to be particularly psychologically minded and had moderate skill deficits in assertive communication, trust, and friendship skills. Given her avoidant personality structure, it was anticipated that she would have difficulty discussing personal matters with health providers, and that she would "test" and provoke providers into criticizing her for changing or canceling appointments at the last minute, being late, and the like. Nevertheless, she continued to be nicotine abstinent some 3 years after completing a smoking cessation program. Her support system includes only minimal contact with an older female cousin and a pet dog.

### *Decreasing Symptomatology and Functional Impairment*

A biopsychosocial treatment plan was developed. This plan specified a number of treatment targets, including ameliorating symptoms, increasing trustfulness, making workplace accommodation, and returning to work. The *biological targets* were to reduce and eliminate depressive symptoms. The *psychological targets* were to reduce shyness, to increase trustfulness, and to increase assertive communication. Finally, the *social/relational targets* were to decrease shyness and increase friendship skills, to decrease job stressors through workplace accommodation and return to work, and to expand the social support system.

These goals were designed to facilitate therapeutic outcomes by maximizing therapeutic leverage while minimizing the influence of previous perpetuate and other forms of resistance to change. An initial treatment agreement was established for eight 45-minute individual sessions combining medication and brief psychotherapy. These sessions focused on symptom reduction and returning to work.

The biological target of depressive symptomatology was first addressed. Elicitation of Jessie's explanatory model of her illness and treatment expectations suggested she would be a good candidate for medication. A decision was made to refer Jessie to her family physician whom she was quite fond of rather than to a physician, such as a psychiatrist, whom she did not know or have a reasonable level of trust. For someone like Jessie, who is overly cautious, the placebo effect can be easily triggered by a referral to a trusted provider.

The clinician contacted the family physician and clarified the nature of collaboration and suggested the need for a medication

that would not have the kind of side effects that would easily dissuade Jessie from compliance. A medication trial was begun, apparently without untoward effects. Within 15 days, Jessie's sleep and energy had returned to baseline.

Because job circumstances stressors had triggered Jessie's disordered response, the goal of reasonably returning Jessie to work might not be achieved without some workplace accommodation. A provision of the Americans With Disabilities Act of 1990 is that the employers must reasonably accommodate an employee's disability, including the kind of psychiatric disability manifest in Jessie. This would require some measure of collaboration between the clinician and Jessie's work supervisor. After getting a signed release from Jessie, the clinician contacted the work supervisor about issues of work stress, peer support, and possible job accommodation. The supervisor agreed that Jessie needed a familiar, trusting social support and was able to assign one of her coworkers to the same office to which Jessie had been moved.

With regard to some of the other social and psychological targets, the clinician and Jessie mutually agreed that skill-oriented group therapy was probably the treatment of choice to increase trustfulness and decrease her social isolation. Aware that Jessie's pattern of avoidance would make entry into and continuation with the group difficult, the therapist planned for the individual sessions to serve as a transition into group, after which shorter individual sessions would focus on medication management, probably on a monthly and then bimonthly basis.

Individual sessions continued with gradual transition into a time-limited group therapy focused on interpersonal skill development. It was predictable that Jessie would test the prescribing clinician and group therapist's trustability and criticalness. Throughout treatment, both clinicians continued to be mindful of the therapeutic leverage (success with nicotine abstinence, relations with cousin and pet, and close-knit typing pool) as well as the perpetuants that would likely hamper treatment. As Jessie's depressive symptoms ameliorated and a maintenance medication schedule was established, the prescribing clinician began preparing her for transition into the group. Because of her fear and ambivalence of the group process, the clinician suggested, and Jessie agreed, that it might be helpful to meet with the therapist who leads the interpersonal skills group she was slated to join. During the fourth individual session, the group therapist was briefly introduced to Jessie and a discussion of a three-way treatment agreement ensued. The three agreed that Jessie would continue in individual weekly appointments concurrent with weekly

group sessions. Assuming things were proceeding well enough, sessions with the prescribing clinician would be reduced to monthly medication checks.

In a subsequent two-way discussion between group therapist and clinician, it was concluded that there was little likelihood that projective identification and splitting would be issues with Jessie. Instead, difficulties maintaining active group participation and follow-up on "homework" between group sessions were predicted. The clinician agreed to encourage and support Jessie's group involvement in his concurrent individual sessions with Jessie. Finally, the therapist and psychiatrist conferred after the third group session regarding the transition from weekly to monthly sessions with the prescribing clinician.

### *Maintaining Treatment Gains and Preventing Recurrence*

Jessie's progress was sufficient that after 10 weekly group sessions, she graduated from the group. She remained on antidepressants for nearly a year, after which the monthly medication management sessions were weaned and discontinued. Because this was her first episode, one that was acute and reactive, and there was no family history of a mood disorder, her chances of a recurrence of major depression are quite unlikely. At a follow-up session 18 months later, Jessie showed that she continued to work, was asymptomatic, and was functioning well with regard to all the life tasks. At that time, her GAF (Global Assessment of Functioning Scale) was estimated to be 78. Furthermore, Jessie was proud to announce that she was engaged to marry a coworker.

## Clinical Application With Couples

Alan, age 35, and Katie, age 33, had been married 14 years when they presented for couples therapy with both acute symptoms and chronic issues. They have one 11-year-old son, Joey, and were experiencing financial problems because of Alan's job loss some 8 months ago. He had been the vice president of marketing for about 7 years for a major corporation that had dramatically been restructured, which effectively eliminated his position. After losing his job, Alan became increasingly quiet and socially inactive. However, full-blown depressive symptoms seemed to erupt only about 6 weeks ago. Because of his insomnia, decreased concentration, lack of

energy, constant rumination about being a failure, and anhedonia, it was not surprising that he reported that he had little motivation to search for a job. Even though 2 weeks earlier he had started on an antidepressant prescribed by his family doctor, he did not seem to be responding. Furthermore, Katie complained that Alan seemed to have no sexual desire and had become impotent in the past few weeks. It was also increasingly difficult for Alan to get out of bed in the morning. Even though Alan received a substantial severance package, Katie had recently shifted from part-time to full-time work as an account executive for a telemarketing firm to support the family as Alan's benefits would stop in 3 weeks. She was both worried and angry about this.

For the past 3 years, Katie has been in psychotherapy for chronic subclinical depression, which was diagnosed as dysthymic disorder. She had worked with two therapists during this period but seemed to have made little progress in reducing her sense of being constantly depressed. Katie began a low dose of Prozac prescribed by her gynecologist, but since it had no apparent effect after a week, she stopped it. Recently, Katie realized that not only was her own life not improving, but her marriage was quickly deteriorating. Her husband, who has always been a steady and faithful ally, had become increasingly depressed and withdrawn after losing his job. And now, he was sexually impotent, which strained their relationship even further. In desperation, Katie put her individual therapy on hold and sought out couples therapy.

In short, Katie initiated the appointment for couples therapy because of her frustration with Alan's job search, his emotional unavailability to her, increasing difficulties with their son Joey acting out at school and home, and financial stressors. Her frustrations had peaked the week before when Alan just shrugged his shoulders when she reviewed how bleak the immediate future appeared. It was then, in desperation, that she gave Alan the ultimatum: "Start doing something about these things or I'm leaving." Alan agreed, reluctantly, to couples therapy.

### *Engaging the Couple in the Treatment Process*

The intent of the first session or two is to establish a working relationship that is sufficient to engage the couple in the therapeutic process. A basic premise of biopsychosocial therapy is that the client or couple will leave sessions, especially initial sessions, with a sense of having derived some tangible benefit. It is often important to leave the couple at the initial interview with a feeling of

hope. By providing hope, the clinician often can help the couple to settle down and begin to benefit from the therapeutic process. Alan and Katie arrived early for the first interview but came in separate cars. Katie initiated contact with the receptionist and clearly dominated the early part of the conversation of the first session, whereas Alan seemed pained and preoccupied.

A common tactic of biopsychosocial therapy for engaging the couple is to initiate some clinical interventions in the first session. Unlike high-functioning and minimally distressed individual clients for whom extended in-depth evaluation typically precedes treatment intervention, clinicians practicing biopsychosocial therapy typically treat individuals and couples who are experiencing acute distress or dysfunctioning and in need of immediate intervention. Such interventions can range from hospitalization to medication or to some environmental intervention such as a medical leave from a job or extrication from an abusive or nonsupportive living arrangement. That the clinician responds quickly and decisively engenders a sense of trust and hopefulness in the individual or couple, which usually facilitates engagement. When such immediacy is present, the strategies of establishing a collaborative relationship, performing a functional assessment, and effecting symptom reduction and increased functioning tend to parallel one another in the early sessions.

It seemed clear that both spouses wanted and needed help. However, because Alan was clinically depressed and so was perceived as a "patient," the clinician thought it necessary and useful to socialize the couple to a systems perspective for the conjoint treatment. It was framed that neither of them was "sick" and that each was simply expressing in his or her characteristic style what neither had "permission" or "ability" to verbalize. Both responded favorably to this perspective. It was also framed that their symptomatic behavior was their attempt to communicate with the other. Not only did the receiving partner not understand the communication, but the sending partner was not completely aware of the message. Thus, an important task of treatment was to accept responsibility for sending the message, that is, acknowledge that a message was being sent, and to then clarify the message. Only then could each decide how to respond favorably to the message being sent.

### *Performing a Functional Assessment*

In biopsychosocial therapy, assessment and intervention/treatment are closely related and proceed by phases. Of necessity, effective assessment deals with both the marital subsystems and the

individual and personal subsystems. Formal assessment for this particular couple involved both individual and systems measure: the Millon Clinical Multiaxial Inventory (Millon, 1983), the Marital Inventory (Dinkmeyer & Dinkmeyer, 1983), and the Self-Report Inventory (Beavers, Hampson, & Hulgus, 1985). Alan also was asked to complete the Beck Depression Inventory after the first session. He scored a 23 on this measure, which confirmed the clinician's clinical impression of major depressive episode. The Millon scales indicated the involvement of significant personality factors in both, with compulsive, passive–aggressive, and dependent features in Alan and histrionic and dependent features in Katie. The Self-Report Inventory suggested that the marital relationship was characterized by a mixed style (i.e., enmeshed in some areas and disengaged in others) while being primarily in the mid-range level of functioning. The Marital Inventory confirmed the history provided by the couple: that there were notable problems in communication, finances, and child rearing. However, it also indicated the presence of significant intimacy issues that the couple initially denied when the couple's relationship history was taken.

Developmentally, Alan is the youngest of three children. His father was a real estate broker and his mother an elementary school teacher. Alan's father had been treated for depression in his late 30s and had died at age 45 of a sudden cardiac arrest after exercising. He was described as an ambivalent man who had a difficult time being a breadwinner. Alan's parents' marriage was described as being highly conflictual, with frequent bickering and a variety of sexual concerns. Alan's mother was a caregiver who never remarried and continues to spoil her youngest son. Both Alan's older siblings have professional careers and stable marriages.

Katie was an only child. Her father was a comptroller for a grocery chain who was dependable and reliable. Her mother is an accountant by profession but has not worked in that capacity for several years because of depression and anxiety attacks. It appears that her mother experiences agoraphobia, which has essentially kept her homebound for as long as Katie can remember. Katie's mother apparently has refused treatment of any kind.

Alan and Katie have been married for 13 years and have known each other for more than 19 years, having grown up in the same suburban neighborhood. They met and began dating in high school, and neither had serious relationships with others. Their early years of marriage had been quite uneventful, and marital satisfaction during those years was described by both as relatively high. Recently, that had all changed. Their 11-year-old son, Joey, had been recently di-

agnosed with ADHD, for which he was taking 5 mg of Ritalin three times a day. The treating child psychiatrist indicated there were also some features of oppositional defiance. Katie was furious that Alan said that taking medication was proof that their son was just as hysterical as she was. Joey had always been closer to Katie than Alan, and lately Alan seemed even more removed from Joey. Katie believed that Joey was acting out to get Alan's attention.

The following diagnostic and clinical formulation was developed. In terms of a *DSM–IV diagnostic formulation*, an Axis I diagnosis of major depression, single episode, moderate and marital problems, along with an Axis II diagnosis of compulsive and passive–aggressive features is noted for Alan, whereas an Axis I diagnosis of depressive disorder NOS and marital problems, along with an Axis II diagnosis of personality disorder NOS with histrionic and dependent features is noted for Katie.

Similarly, a *clinical–systemic formulation* can be stated as follows: This couple is currently experiencing some acute stressors that complicate their individual and couple's dynamics. Alan's ambivalence, reflecting his compulsive and passive–aggressive personality style, seems to complicate his return to gainful employment, which increases his wife's current distress. Katie functions in a more histrionic and dependent manner by indirectly demanding attention from Alan, but she is frustrated by his relational ambivalence and sexual and emotional impotence. Their son Joey appears to be overly identified with Katie, and this enmeshment seems to reinforce Alan's distancing from both Joey and Katie. The couple has notable deficits in relational skills, particularly assertiveness, as well as a transgenerational history that predisposes both to maladaptive functioning when under considerable stress. In addition, biological factors (i.e., Alan's clinical depression and medication-induced impotence and Katie's chronic dysphoria) further exacerbate the couple's problems and concerns.

Nevertheless, they appear to be adequately motivated for treatment and the prognosis seems to be fair-to-good. Combined treatment involving systemic, cognitive–behavioral, and psychoeducational interventions seems indicated for psychological and social factors and medication and psychoeducational interventions for the biological factors.

### *Reducing Symptoms and Increasing Functional Capacity*

A biopsychosocial treatment plan identifies the biological, psychological, and social target areas for intervention. As delineated by

the biopsychosocial assessment, the *biological targets* for Alan were depressive symptoms and medication-induced impotence, and for Katie was chronic dysphoria. The *psychological targets* for Alan were pessimism, perfectionism, and difficulty with direct expression of feelings, and for Katie, demandingness and overdependence. Finally, the *social–relational targets* were deficits in intimacy skills, limited social activities, and deficits in assertive communication for the couple and the triangular relationship among Alan, Katie, and Joey.

From a biopsychosocial therapy perspective, the initial focus of treatment typically addresses symptomatic distress. Usually this involves biological treatment targets, especially reducing or eliminating acute symptoms. After sufficient symptomatic relief is achieved, treatment can shift to increasing functional capacity. Typically, this means that psychological and social/relational targets are subsequently addressed.

Because of his obvious acute distress, Alan's vegetative symptoms of depression were first addressed. His explanatory model of his illness and his treatment expectations, including his fantasies about taking medication, were elicited. Alan believed that his symptoms were the result of job loss and a chemical imbalance in his brain, which he hoped would be well treated with medication and therapy. He made no connection between his impotency and the antidepressant he had been prescribed because no mention was made of potential sexual side effects. It was mutually decided to switch to another antidepressant (Celxa), which was reportedly less likely to induce impotence. Although Alan was insistent that another medication trial would "work this time," the clinician remained mindful of Alan's ambivalence and so made no predictions about the medication's expected efficacy. He actually cautioned Alan not to get his hopes up too high. The medication was begun at a low dose and was increased over the next 7 days. By the 12th day, Alan reported that he was feeling considerably better.

Katie indicated that she wanted to try medication again, convinced that she had not given the Prozac she had been prescribed earlier a sufficient trial. Eliciting her fantasies about medication were quite instructive. Not only did she believe that Prozac would be a magical solution to her subclinical depression, but she also expected she would lose weight in the process! When neither happened within 2 weeks, she disappointedly stopped taking it. Psychoeducation about likely treatment response was provided and discussed sufficiently to dispel her prior notions.

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Next the psychological and social–relational targets were addressed. Their interlocking personality dynamics were pointed out. Katie's depression was reframed as a way of asking to be cared for, and her moodiness as her trying to keep the relationship together. She valued love and the marriage and family, and she wanted them to be happy. She was trying to keep them together and to look out for her husband and his health. Alan was trying to keep his family together, too, and his perfectionistic manner was reframed as his way of showing caring and concern. In effect, they were told that their symptoms were serving the same purpose, just in different ways. The challenge for both of them was to communicate their desires in more direct, constructive ways.

Attention was then directed at rebalancing their relationship pattern. This proved exceedingly challenging, because power was rather evenly distributed: Alan would manifest his aloofness, perfectionism, and passive–aggressiveness until Katie became upset and hysterical, at which point she would regain power of the relationship. Then, Alan would calm the situation by capitulating, which she liked, but eventually resulted in him regaining power again. She would allow this until she felt he cared more about his needs than her, after which she would grow impatient, become upset, and the cyclical pattern would repeat itself. This cyclical pattern was pointed out to them. Alan immediately grasped it and its ramifications, but Katie found it harder to comprehend.

Boundaries and intimacy were not as easily addressed. A triangle existed, with their son Joey vacillating between being a husband-surrogate for his mother when Alan was away from home, to his acting like a friend to his father when Alan was home. His presence both fueled the maladaptive cyclical pattern and perpetuated the very problems that, without his presence, might lead to some kind of resolution. The next several weeks of conjoint treatment focused on these issues. Although there may have been value in switching to a family therapy mode at this point, there were inherent dangers as well. Introducing Joey into conjoint sessions could perpetuate the very issue he was helping to maintain: intruding on the couple's relationship.

Instead, efforts were undertaken to strengthen the couple's bond without the son in the session. Psychoeducation including skills training was begun. Assertive communication was the first focus of training. This was accomplished within and between sessions by role playing and focused practice. To enhance their relational intimacy, the couple made a commitment to arrange a date following each conjoint treatment session. In addition, the clinician framed

to Alan that his son needed some fatherly advice now that he was moving into adolescence and that Alan needed to expand his own social network. To Katie, it was framed that by encouraging her son to separate, she would be strengthening both her marriage and her son's future. Both agreed, and a weaning process began that was aided by the son's increasing involvement in soccer and other team sports at his junior high. Alan became involved as an assistant to the soccer coach. Subsequently, Joey seemed to manifest fewer problems at school and home, such that their pediatrician was able to lower his Ritalin dose.

Alan's controlling behavior and Katie's emotionality were mutually complementary. She was encouraged to teach him to be more emotionally expressive, and he was urged to be her consultant on matters of organization regarding household duties. They grasped this way of working, and though they still experienced some conflict they were able to become more affectionate with each other.

Similarly, a psychoeducational approach to insomnia was introduced. By modifying his evening schedule and attending to other aspects of sleep hygiene, Alan's chronic insomnia was gradually replaced with restful sleep within 3 weeks. Efforts to reduce his worrisome ruminations were addressed by learning "productive worry time." Thirty-minute sessions of productive worry, which involved Alan writing out his worries in a journal, were prescribed as daily homework to modulate and better control his ruminations. Finally, after about 10 conjoint session, 6 separate individual sessions were scheduled with each spouse. Cognitive restructuring was used to modify Alan's perfectionism and pessimism.

The clinician was able to use paradox and reframing effectively to help the couple continue to do what had to be done. The art of reframing it as constructive, rather than destructive, however, changed the pattern of interaction and the method in which Alan and Katie relate with each other. The clinician initiated efforts to reverse their pattern of nonproductive dialogue. The session continued with both Katie and Alan learning to appreciate the other's parenting strengths (i.e., Alan's patience vs. silent withdrawal; Katie's firmness vs. demandingness). As treatment progressed, direct intervention of the presenting marital issues became a principal focus. The relative importance of issues changes over time. Katie, for example, was still discouraged about Alan's lack of employment but was much less resentful, because he had begun to meet with a career counselor. They began to communicate more directly with each other, to create boundaries, and to resolve problems as they

occurred. Throughout the couples therapy, the clinician better understood and appreciated how Alan and Katie responded to conflict. They seemed to enjoy conflict as long as it did not get too far out of hand. When this occurred, Alan tended to shut down, whereas Katie tended to increase her demands and pursuit of Alan. To help them deal more effectively with conflict, the clinician had to obtain the compromises necessary to secure accommodation and, eventually, resolution. The couple learned how their specific issues could be resolved and, specifically, what each of their roles had to be for effective resolution.

As Katie explored her hurt and resentment about Alan's emotional and sexual distancing, Alan began to understand how his passive–aggressive pattern of withholding intimacy safeguarded his belief that he was still a "perfect" husband lover because he did not want to risk failing at intimacy, but that the price he—and Katie—had to pay was too high. Subsequently, he agreed to begin to initiate and participate in sexual relations and to commit to fulfilling more of Katie's expectations.

### *Maintaining Treatment Gains and Preventing Recurrence*

A review of progress in the 20th conjoint session revealed that the couple had resolved many of the issues that they had requested help with. As Katie's depression became more under her control, she experienced more satisfaction in her relationship with Alan. Alan was able to secure a position as a faculty member in an executive MBA program teaching strategic management. Teaching is something he had always wanted to do but had not because his father had insisted that "only those who can't, teach." Not wanting to be perceived by anyone, especially his father, as a failure, Alan had banished the thought of teaching, until now. He gained greater control over his schedule, worked less hours and more efficiently, and found more pleasure at home.

After 22 conjoint sessions over a period of 9 months, the couple progressed to the point of quarterly follow-up sessions. A subsequent follow-up session was scheduled in 2 months to monitor progress. Individual therapy would continue with Alan to focus on the way his perfectionism and passive–aggressive pattern could unbalance the marital system. Medication monitoring on a 3-month basis over the next 12 months was also arranged with Alan. It was anticipated that medication could be weaned and discontinued at that point. It was mutually agreed that Katie would take a "thera-

peutic holiday" from individual therapy but would check in with the clinician in 6 months.

## Summary

Biopsychosocial therapy can be described as an integrative approach for conceptualizing and implementing treatments when biological as well as psychological and social/systemic factors are present. Rather than being a "new" treatment approach, biopsychosocial therapy is a set of systemic strategies for planning and implementing effective treatment interventions in terms of a biopsychosocial perspective. Four stages of treatment were described and illustrated, as well as three specific treatment tactics. Although these stages are not unrelated to phases common to other therapeutic approaches (Beitman, 1993), biopsychosocial therapy tailors these strategies to the particular needs of clients and couples presenting with a complex of symptoms, functional impairment, and concurrent medical or psychiatric conditions that tend to undermine or complicate treatment. It is quite likely that many experienced clinicians are already using many or all of these strategies and tactics intuitively or without acknowledging their reliance on the time-honored biopsychosocial perspective.

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PART III

# INTERVIEW WITH A PIONEER IN INTEGRATIVE AND BIOPSYCHOSOCIAL THERAPY

# 5

# The Clinical Practice of Integrative and Biopsychosocial Therapy With Individuals and Couples: A Conversation With John F. Clarkin, PhD

John F. Clarkin, PhD, and
Len Sperry, MD, PhD

John F. Clarkin, PhD, is a major figure in the development of integrative approaches to psychotherapy and marital and family therapy. He is currently professor of clinical psychology in psychiatry at Cornell University Medical College and is director of psychology for the New York Hospital. Dr. Clarkin has published widely on marital and family therapy, on the biopsychosocial model, and on integrative therapy. Recent book publications include *Affective Disorders and the Family: Assessment and Treatment* (Clarkin, Haas, & Glick, 1988), *Marital and Family Therapy* (4th ed.; Glick, Berman, Clarkin, & Rait, 2000), *Psychotherapy for Borderline Personality* (Clarkin, Yeomans, & Kernberg, 1999), and *Guidelines for the Systematic Treatment of the Depressed Patient* (Beutler, Clarkin, & Bongar, 2000). In the following interview, Dr. Clarkin converses on a variety

of issues pertinent to the practice of biopsychosocial and integrative therapy.

**Sperry:** In the past 5 years, the expectation for an increasing number of nonmedically trained therapists has been to utilize the biopsychosocial perspective in their clinical work. This has been a challenge for many who were trained in a primarily psychosocial mode. How did you get involved with the biopsychosocial approach in your research and clinical practice, and what's been your experience?

**Clarkin:** I have worked in a medical school and psychiatric hospital for almost 30 years. In such a setting, one is exposed to individuals who suffer from serious and persistent mental illness. Over that time span, the psychiatric medications for the seriously mentally ill have improved significantly. At a practical level, one can use a wide range of treatment—medication, individual therapy, group therapy, psychoeducation, family approaches—to assist the seriously mentally ill and their families.

Much has been said, especially by nonpsychiatrists, criticizing the so-called medical model. Indeed, I am not defending all aspects of the medical model and all that is implied by that term. There are many positive things about a medical orientation. It compels one to focus on important and key symptoms and behaviors. It forces one to articulate these most problematic areas and formulate treatment goals around them. When one is confronted with serious and chronic mental illness, such a targeted approach provides structure to oneself, the patient, and the family and provides a directed and hopeful orientation to treatment.

It was a small step from the clinical experience of the seriously and chronically mentally ill to research approaches with this population. If it makes sense clinically to combine treatment approaches spanning the biological and psychological domains, it is then informative to assess the relative impact of the biological and psychosocial treatment approaches and their combination.

I believe that the goals and results of psychosocial treatments and medication treatments are somewhat different and complementary. For example, in the treatment of bipolar disorder, we found that medication treatment and compliance with medication treatment accounted for changes in bipolar symptoms. In contrast, we found that medication treatment combined with

marital treatment led to greater functioning on the part of the patient. To put it simply, medications help control symptoms but do not assist one in learning functional behaviors.

**Sperry:** You teach clinical psychology interns and give presentations to practicing clinicians. What do you tell them about the clinical relevance of the biopsychosocial approach to therapy?

**Clarkin:** We look for psychology interns who have some background in biology and psychology. It is becoming more and more evident that even at a conceptual level one cannot think of the mind without relationship to the brain; one cannot think about thoughts and feelings and attitudes without considering bodily processes of perception, emotion, and emotion regulation. In this era of functional MRI [magnetic resonance imaging], we can actually see the living brain in its processes of perception, learning, memory process, recall, and so on. To understand human functioning, one must consistently consider nature and nurture.

I think the clinical relevance of a biological and psychological approach becomes evident to the interns as it did for me in being exposed to patients with serious and persistent mental illness. With increased pressures from third-party payers to provide rapid and focused intervention, one is forced to consider various elements in the treatment, elements that are most efficacious and least costly.

In talking to practicing clinicians, I emphasize the nature of the pathology before going on to developing a treatment or a treatment plan for the individual. In this approach, one reviews the relevant biology, development, and psychology of the disorder in question. For example, borderline personality disorder can be seen as a disorder at the phenomenological level in which affect dysregulation is paramount. In order to understand these aspects of affect dysregulation, one must go to the early experiences of the borderline patient. These are often characterized by disruptions in the early attachment between some maternal figure and the infant that is hypothesized to leave damages in the ability of the developing individual to attach to others with security and safety. At the biological level, we know from animal models that early stress between mother and offspring creates both acute and chronic conditions in the hypothalamic pituitary adrenal axis. These biological systems and their disruption are consistent with overreactions to minor stimuli and a slow return to physiological baseline.

**Sperry:** There is also the expectation that therapy should be more tailored and integrative. Do tailored and integrative efforts re-

ally make a difference in clinical practice? You've done quite a bit of research and written much about this. What does this research show?

**Clarkin:** Let me address this question at a clinical level first of all. I have noted for a long time that clinically the individual therapist or the individual psychiatrist providing treatment to the patient makes an enormous difference. I know clinicians who can time and again be of help to seriously disturbed and often self-destructive borderline patients. And I know some psychiatrists who are extremely effective in getting even very treatment-resistant bipolar patients to adhere to medication compliance, while other psychiatrists fail with these patients and have a high dropout rate. This means, I think, that these therapists are adaptive. They have a sense of themselves, they are not threatened by the patient's resistance and at times hostility, and they are able to touch the positive aspects of these patients, be they ever so small, to help them cope with serious deficits. I think this is clinical integration and tailoring of the treatment to the individual patient at its best. It means to me that both from a clinical point of view when one is looking for supervision and from a research point of view, we should do a better job of finding out how these expert clinicians tailor their approach to the individual patient.

In contrast, it has become an accepted research truism that "all have run and all deserve prizes." It is very difficult to find research differences between different treatments defined at the level of techniques. And indeed many articles have been written on why this is so, and it's not necessary to repeat that here. I think with time our abilities to use instruments that detect meaningful areas of change and designs that are capable of detecting not only the amount of change but the rate of change will begin to illustrate the difference between expertly tailored treatments and those that are lacking in this manner. Now the difference in outcome may not be due to cherished differences in the schools of therapy and related techniques. It may reside in some dynamic interaction between patient–therapist chemistry, strengths of the patient, and differentiated treatment approaches.

I would refer the interested clinician/researcher to a recent book that Larry Beutler, Bruce Bonger, and I have done on the treatment of depression (*Guidelines for the Systematic Treatment of the Depressed Patient*; see Beutler, Clarkin, & Bonger, 2000). In this book, we have generated models with existing

data that suggest that tailoring the treatment to certain patient characteristics leads to a better clinical outcome.

**Sperry:** What are the kinds of challenges and difficulties you've noted in clinicians and trainees who attempt to become more integrative in their clinical work?

**Clarkin:** The answer to this question depends on what one means by integrative. Our psychology trainees working in a medical school/hospital setting have no difficulty adapting to the use of pharmacotherapy combined with various kinds of psychotherapy. Some of these trainees even expect in their professional lifetimes to have prescribing privileges themselves, a vision that I never imagined when I was at their stage of development. More difficult I think is combining different psychotherapeutic techniques in a way that the trainee is relaxed and feels personally authentic. For example, we currently require that postdoctoral fellows specializing in the treatment of personality disorders learn both Linehan's (1993) dialectical behavior treatment (DBT) and Kernberg's (Clarkin, Yeomans, & Kernberg, 1999) transference-focused psychodynamic (TFP) psychotherapy. These trainees take seminars in both orientations and have several patients under supervision in each contrasting orientation. In this training, they are asked not to mix the treatments, but to carry out each manualized treatment in the way that it is described and taught by their supervisor. It has been most informative for me to watch this process and to discuss with the trainees their experience of learning both orientations at the same time. Some begin being much more comfortable with one orientation than the other, for example, a male postdoctoral fellow whose graduate training was predominantly cognitive–behavioral who took to DBT but had difficulty grasping the essence of TFP. It's interesting to explore with them what happens over time. I think the open-minded trainee begins to see the positive aspects of both approaches. It's my impression that at the end of their training they begin to combine the orientations in ways that seem most beneficial to them. How they tailor and match these processes to the individual patients remains to be seen. I would like to think that research has made us humble. Our intense beliefs in one school or orientation over another is not productive, but open-mindedness to different skill sets may lead us to the best way to help the individual patient.

**Sperry:** What have you found that facilitates the process of learning to utilize the biopsychosocial and integrative approaches to therapy?

**Clarkin:** There is nothing more important than human role models. Trainees need to identify with and imitate (in their own style) the style and skills of their mentors. In this regard, it is unfortunate that our academic system fosters the belief that an individual must develop a reputation for himself or herself by emphasizing how unique one's approach is and maximizing differences from others. This scholastic narcissism breeds individuals who emphasize their individuality, and integrative approaches are not rewarded.

**Sperry:** You've been involved with research and clinical practice involving couples therapy when one partner has bipolar disorder. What did you learn from these endeavors that would be clinically useful for therapists?

**Clarkin:** Both clinically and in our research, I was astounded and impressed with the heterogeneity of the patients suffering from bipolar disorder and the variability of their spouses. All the patients were alike in the diagnosis of bipolar disorder, but some were predominantly depressive, others predominantly had manic episodes, some had brief episodes of illness and were quite normal between episodes, others were chronically ill to the point where it was difficult to see when they had come out of the illness. Some, a minority I might add, had serious personality pathology, whereas others had very little. Add to this the heterogeneity of their mates and you begin to realize the wonderful variety of individuals that one sees.

As is probably obvious, in the first phase of treatment you strive for medication compliance and stabilization of symptoms. If one is successful in achieving some form of stabilization, therapist and couple can go on to the marital style and issues. Before our research, we thought that the spouse would probably complain about the illness and its impact. It turned out that invariably we were wrong. The spouses rarely spontaneously complained about the mate in terms of the bipolar disorder. They almost always conceptualized the mate in nonillness terms. As one might expect, the most difficult situations were those in which the mate was quite critical of the spouse, often not mentioning the bipolar illness at all.

At another level of investigation, we have found differences within family constellations. Parents with a bipolar adult child are accepting of the offspring and tend to be less critical than spouses. In contrast, it is especially the female spouse of the male bipolar who is most likely to be chronically critical. We do not conclude that women are more critical than men, but

rather hypothesize that marriage involves the selection of a mate who is expected to provide through a productive work role. Male bipolars are often impaired and have a variable or downward course of work and productivity which can frustrate the expectations of a spouse.

**Sperry:** Many therapists find it difficult to work with couples when borderline personality dynamics are involved in one or both partners. What clinical strategies have you found helpful?

**Clarkin:** It is important to note first that borderline patients are quite heterogeneous. To oversimplify matters somewhat, borderline patients typically have two or more comorbid conditions on Axis II. Borderline patients without comorbid narcissistic and/or antisocial personality disorder are quite different from those with those comorbid conditions. The latter make more serious suicide attempts, are most self-destructive, and are very difficult to treat. So a couple in which one patient is borderline without comorbid antisocial and/or narcissistic personality disorder is much more treatable. In addition, we have noted that, most relevant to couples, borderline women tend to be either sexually inactive or sexually active and often sexually promiscuous. Thus, it would be important to note the level of sexuality present in the marital relationship. Furthermore, the quality of object relations or the quality of an ability to relate to others in an emotionally rich and nonmanipulative way varies tremendously across borderline patients. From an attachment theory point of view, borderline patients tend to be either dismissing in their attachments or preoccupied and conflicted. These variables would have an influence on the kind of marital relationship presented to the therapist. The work would be slow and arduous at best, but could be quite rewarding. Another area of focus of course would be to help the borderline patient and/or mate do a better job of parenting than probably they received.

**Sperry:** Finally, I know you would not feel comfortable making grand predictions for all of behavioral health, but what do you personally foresee as the future for the practice of individual and couples therapy?

**Clarkin:** In the short run, the managed-care system is in many instances limiting psychotherapy to very brief treatment episodes with the number of sessions reimbursed under two digits. If this condition continues, I think it could drive talented people away from a career in psychotherapy and that the prognosis would be quite poor. A long-run prediction is harder to make.

Many are now suggesting that managed care has outlived its usefulness and will probably disappear. That raises the question of what mechanisms will be put in its place to control rising medical costs. The wealthy will pay for therapeutic intervention. The middle class will probably be limited by some form of insurance plan to a minimal benefit. Unfortunately, the poor, which often includes the large majority of the chronically mentally ill, will be at the mercy of public funding, which is currently being reduced to medication treatment.

At a more theoretical level, the brief focused cognitive–behavioral treatments for symptom-related conditions (e.g., anxiety, depression, and eating disorders) are dominating the scene. I would predict, however, this scene will not stay static. Many intelligent therapists would be quite bored limiting their clinical interventions to these brief, prefabricated treatments. It is my hope that more creative approaches to helping our fellow human beings will win out.

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In a therapeutic era that reflects increasingly complex clinical realities and sweeping changes in health care, it is essential for mental health professionals to address biological and health issues along with social and psychological ones. This mounting professional and economic need for integrative treatments has necessitated the trend toward biopsychosocial approaches to maximize treatment outcomes. Integrative and biopsychosocial therapy are complete approaches—drawn from diverse theoretical models—that are adaptive to all aspects of the problem and therefore especially successful in working with multiproblem families and difficult-to-treat cases in which conventional treatment approaches have proven ineffective.

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